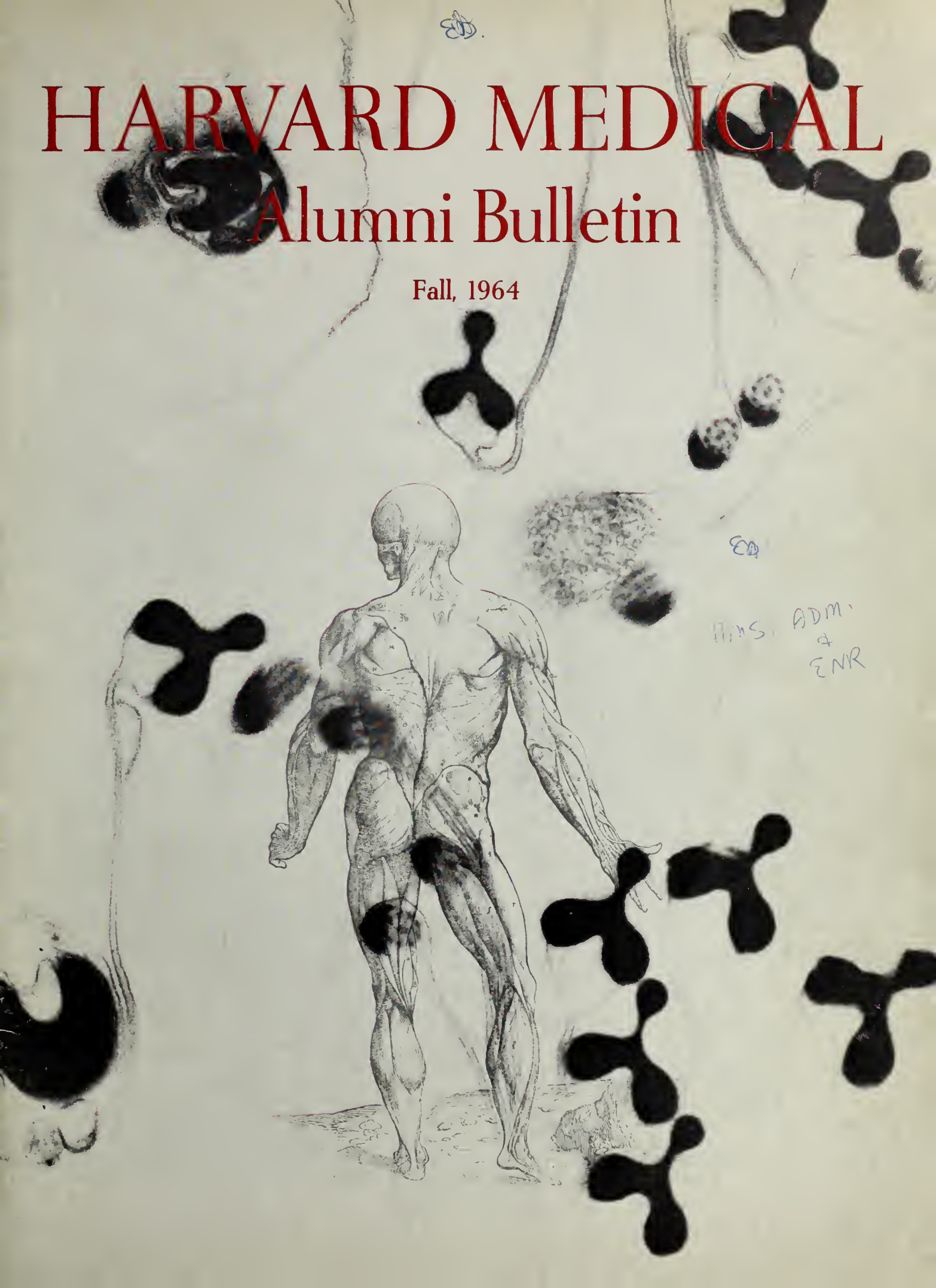
HARVARD MEDICAL
Alumni Bulletin

Fall, 1964



SHATTUCK STREET 1964 –

As a tribute to Dr. Frederick C. Shattuck, teacher and friend of the school, the Van Dyke Street was changed to Shattuck Street in 1933. Dr. Shattuck, who died in 1929, might be quite surprised to see how the character of this private thoroughfare has changed during the past 35 years.

HARVARD MEDICAL ALUMNI BULLETIN

Vol. 39 Fall, 1964 No. 1

Cover: The students entering the Medical School this fall face a gulf between gross and molecular anatomy that grows infinitely wider: one which, paradoxically, diminishes the complexity of largeness and increases the complexity of smallness. Superimposed upon an etching by Vesalius is a photograph of salamander (Triturus) sperm magnified approximately 28,500 times. It was taken by Dr. Don W. Fawcett '42, head of the department of anatomy. Cover photo by Herman Goslyn.

LETTERS

More Participation by the Eggheads

To the Editor:

I have just finished reading "Socialized Medicine a Double Edged Sword" — a most timely, pertinent, informative article. My congratulations to the author for the interest and concern with the socio-economic aspect of American medicine that prompted him to write. I was most impressed with two bits of the article: first, with "Now, having worked under the system of socialized medicine, I take a new approach to many of these issues" and second, with his entire last paragraph which I shall not quote.

Strangely enough, I have just reviewed for the A.M.A., "Trends in the National Health Service" by James Farndale. . . . In this book, many of the frustrations he mentioned are not admitted or are glossed over, but one cannot miss the suspicion that the general feeling of informed Britishers is one of resignation ("We're stuck with it!") and stubborn determination ("We'll muddle through!").

To return to the two bits of his article that interested me most: I hope Dr. Patton has read Dr. John F. Freyman's "Leadership in American Medicine — A Matter of Personal Responsibility" in the April 2, 1964, issue of the *New England Journal of Medicine*. And I hope, too, that he has read Dr. Leland McKittrick's Special Article, "To What Purpose" in the April 16, 1964, issue of the same journal. I wonder if Dr. Patton was one of the "packed" audience that had to listen to my report as president of the Massachusetts Medical Society when I pleaded for more active participation in local, state, and national medical politics by the "eggheads" as he calls them, by those of "orientation liberal." Believe me, unless the men in those categories do get in and really fight, their hope "to maintain the freedom in which the very best medical practice can flourish" is dead as any dodo bird. There is no doubt that the A.M.A. has suffered and the medical profession's public image has suffered, because of the "Town and Gown" split in medical politics. But both factions are losing! And it's time for a change!

The aspect of it all that bothers me is that it would take so few to start the ball rolling. District society meetings, state society meetings, national society meetings usually are attended only by handfuls and the "old guard" is able to bumble along on the only course it knows. Very few are well informed — many are easily led by a few bulldozing "talk-too-oftens." But a few of the liberals really could raise merry hell in a Norfolk or Suffolk District Society Meeting. There would be a price to pay, as there always is for progress; but the stakes are high.

In California there appears to be some hope — there participation in medical politics involves the majority — and new projects, varied experiments, hard work in making good the profession's promises, and realistic public relations programs are very evident results of this general participation. The Californian doctors haven't yet been able to come up with anything that fires the public's imagination. But they're trying!

What is the form of "suitable legislation" that Dr. Patton mentions in his last paragraph? Who is going to frame it: vote-hungry politicians, starry-eyed social planners, or dedicated physicians? Many of us in the A.M.A. are taking a public stand with the "antediluvian" policy of the A.M.A. because we don't know what else to do, how else to stave off obviously undesirable socialization until some leader or leaders come along who can show us something better. There are faint stirrings in the Council on Medical Service, but the voices needed to really fire that Council up have just not been heard.

If the present H.R. 3920 is licked this year, if the social security approach to medical care of the aged does not become law during this session of Congress, the medical profession will have another chance to offer government a better solution to this and to some other problems. It may be melodramatic to say that this will be the last chance, but there is a fearsome aura of reality in the notion.

The 30 to 40 eminent physicians who went to the White House to endorse the King-Anderson Bill left me cold. Right now I can think of them only as well-meaning, but politically lazy medical citizens who will applaud any "do something" approach.

Dr. John Knowles is setting a good example for the group Dr. Patton represents. He is not standing aloof, he is getting his feet wet in medical society affairs, he talks with and listens to the old guard, and he has ideas! Not every doctor likes his ideas, but he's willing to put them in the crucible for the test by fire and this is what we need so badly.

David W. Wallwork '30
North Andover, Mass.

Les Jeux Sont Finis

To the Editor:

May I rise in defense of your foreign language editor who is taken to task by Mrs. Isabell M. Howard (summer issue, p. 55) for what was apparently some error in his rendition of "les jeux sont faits," which I missed. This is a bit like the pot calling the kettle black, since Mrs. Howard makes two egregious errors which should make a first year high-school student blush. There is no such word

as "avriez," which of course should have been "auriez." Worse yet, there is no acute accent on the second "e" in "écrire," a mistake exhibiting an appalling ignorance of French grammar.

Incidentally it might be well for your own editor to glance briefly at his thumb-worn French grammar and so discover that his "plaît" should have a circumflex accent. With no wish to be pedantic, but just in the interests of Harvard accuracy, à bientôt,

LYMAN G. RICHARDS '19
Wellesley Hills, Mass.

To the Editor:

It was flattering to have my comment on a French phrase published in the summer issue. But I was dismayed to see that, in correcting the original mistake, you had made three new ones: omitted the circumflex accent on plaît, put a "v" instead of a "u" in auriez, and put an extra acute accent on écrire. I hate to have my name below so many blunders. Would it be possible to get it right?

Pardon, s'il vous plaît. Vous auriez dû écrire "Les jeux sont faits."

ISABELL M. HOWARD
Detroit, Mich.

(We confess! The **Bulletin** *blundered on purpose, simply to test the linguistic accuracy of its readers. Eds.)*

We the Class of 1967, proudly announce the arrival of the annual Second Year Show, on December 5, 1964, at 8.00 P.M., in the Vanderbilt Hall gymnasium. As usual, the show will be a fulsome blend of farce, musical comedy, and some fact. Complementing the presentation will be a refreshing collation, and we hope you will join us.

The show has always enjoyed substantial "theatrical" success, but recently it has suffered financially. This year we would greatly appreciate support from "Patrons of the Show." The name of each patron will be handsomely inscribed in the program. We hope you will reserve your place by sending $10 to Lary Kupor, Business & Publicity Chairman, Vanderbilt Hall 229, Boston 15, Mass.

Notice To Alumni Fathers Of Sons Who Are Planning to Apply to Harvard Medical School:

The minimal requirements for admission have been modified to include two more: differential and integral calculus for the duration of one year. Before 1964, these two subjects were merely recommended.

Along the Perimeter

Locating the University

Geography is said to be as capable of molding history as are men, and this is certainly the case in the creating of the University of Massachusetts Medical School. Now that the law founding the school is two years old and Harvard Medical Alumnus Lamar Soutter '35 is its dean, the school's trustees have one primary concern: where it should be located. This thorny task has stretched over almost a year, and it is hoped, only hoped, that the special committee of the University's trustees appointed to resolve the question will do so by the end of this month.

Perhaps this is not so surprising, in view of the protracted history of its founding law. For more than ten years millions of words have been written or spoken on whether or not the school should exist. The 1962 Report

Left is one of the 66 sites offered to the new school, a 128-acre chunk of land in Amherst that is next to the University's biology, chemistry and physics buildings.

curriculum tailored to the needs of Massachusetts doctors.

Third, it would especially concern itself with supplying the state with more family doctors, which are much needed.

Last, and most crucial, the new school would increase the total number of doctors in the nation. According to the 1959 Bane Report, half-again more American doctors will be needed by 1975 to maintain the present physician-patient ratio. This means that nearly 3,000 more first-year medical school places must be created over the next seven years. Eight hundred and fifty of these will eventually be created by the opening of 12 new schools, five two-year and seven four-year institutions. Beginning with a small class in 1968, the University hopes eventually to provide 100 of this total.

Since its founding law was passed, the school has been offered 66 sites: some at cost, some free, and some on either city or state property. According to the press, the choice has been narrowed by the committee to four centers: Boston, Worcester, Springfield, and Amherst. The first three have hospitals that might be converted to teaching hospitals. Springfield has one for the chronically ill with 500 beds and 50 acres for buildings nearby. Worcester offers its City Hospital with 46 acres, including the land it covers. The Boston area holds out either its state-owned, 600-bed Lemuel Shattuck Hospital with 75 more acres of Boston State Hospital's land one mile away, or the Boston City Hospital with 23 adjacent acres of Boston Redevelopment Authority property. The University offers a 128-acre site next to its biology, chemistry, and physics buildings on its Amherst campus. All of these packages of land are free.

The final decision on location rests with the University's 22 trustees, upon recommendation of a subcommittee of five members. These include Joseph P. Healey, president of the Middlesex County National Bank, chairman; Dr. Alfred L. Frechette, commissioner of public health and clinical professor of public health practice at

of Massachusetts Medical School

of the Recess Commission on the Establishment of a State Supported Medical School that helped bring the law to pass makes it very clear, however, that such a school should supplement the functions of the three private schools in the state in four important ways:

First, it would attract many of those students who are now going out of the state for their medical education, where most of them face both higher tuitions — the new school has an annual tuition of $200 — and the geographically restrictive admission policies of state schools for non-resident applicants. As of 1961, this group comprised about 50 per cent of Massachusetts residents studying medicine.

Second, the new school could provide a postgraduate

the Harvard School of Public Health; Dr. Harry C. Solomon, commissioner of mental health and professor of psychiatry, emeritus, at the Medical School; Judge J. John Fox, of Dedham Probate Court; and Dr. John W. Lederle, president of the University of Massachusetts. Invited to sit with the committee are Drs. Calvin Plimpton '43A, president of Amherst College; Edmund J. Croce '35, of Worcester; and Lamar Soutter '35.

According to the Association of American Medical Colleges, a new state medical school must have the four following ingredients to attain the highest quality of education: a strong full-time faculty; the manpower and facilities to introduce new and better programs of patient care and research; proximity to its parent institution; and,

most complicated of all, the control of the medical center that develops around the new school. Since World War II, all except two of the nation's new medical schools have built and controlled their own general teaching hospital. Before this time schools placed themselves near one or more large, autonomous, urban hospitals. According to the post-war pattern, a school builds and runs its general hospital so that it will eventually become the focus of a medical center that supplies good, highly specialized care by the newest methods to an area that badly needs it. The general teaching hospital is physically connected to its parent medical school and is staffed by full-time people whose standards of work are controlled by the school. When hospital land is purchased, enough additional space is also bought for the addition of such future units as a Veterans' Hospital, dental school, nursing school, public health school, mental health center, and school dormitories. Past experience across the nation has shown that the minimum requirement of land for the center must be between 50 and 100 acres.

Which of the four potential locations could best satisfy these needs? To begin with Boston: the State Department of Public Health that controls the Lemuel Shattuck Hospital has suggested that a medical sciences building could be built adjacent to the hospital, although the hospital covers most of the land around it. The State Health Department Laboratories nearby are now being expanded and could possibly be adapted for the school's diagnostic work in virology, immunology, and radiation hazards. One mile away is the Boston State Hospital, which is controlled by the State Department of Mental Health. This facility could provide the school with psychiatric patients for teaching, as it presently does for Boston University and Tufts Medical Schools. It might also be adapted to give the new school a modern, 250-bed unit for teaching medicine and surgery. Dr. Solomon, commissioner of the State Department of Mental Health, has also offered the school 75 acres of land now occupied by the women's section of Boston State. To make this possible these facilities would have to be moved next to the men's section of the hospital.

Would the Shattuck center supply care to the state where it is most badly needed? What about new and better patient care and research, or the University's control of the entire complex? The three schools in the area are already utilizing all the patients available for teaching in Boston, and their number is shrinking all the time. In 1948 the Boston City Hospital had a daily census of more than 2,000 patients; by 1963 this had fallen to 869. Not only are the community hospitals diverting patients away, but the population of Greater Boston itself has shrunk three per cent over the last decade. If these two trends continue, a new hospital would certainly not be able to alter existing patient referral patterns. Moreover, the city's three medical schools have helped make the quality of care to the chronically ill at the Shattuck higher than any other in the state. Should the state school be placed next to it, where would these patients go? This question could also be asked about the Boston State Hospital, since it is considered the state's best institution for those with chronic mental illness. Then too, would the school be under the full control of the university if the center is already manned by two state departments?

The Boston City Hospital site poses the same problems. Would not the hospital find its affiliation with the city's three existing medical schools, one which has been mutually beneficial, undermined by an affiliation with a fourth school? Would not the new school find itself committing the timeworn crime of robbing Peter to pay Paul? Although the land offered would be more accessible than that offered by the Shattuck, the ideal acreage for the new school and its center has been set between 50 and 100, rather than 23 acres.

Which of the other three locations — Springfield, Worcester, or Amherst — is the most desirable? Professional surveyors of the areas have emphasized two things. All provide land over which there would be fewer questions of control, and all need a medical center. Outside of the Boston area the state's doctor-patient ratio is very low compared to that of other states, and specialized hospitals are few and far between. Moreover, all three areas have expanding populations. The Worcester area has increased by three per cent in the last decade and the Springfield-Amherst area has grown by 17 per cent in the same amount of time. That areas of comparable population density can support a medical center with enough patients has been proven by such centers as those at Ann Arbor, Duke University, and the University of Arizona. As for faculty recruitment, full-time faculty members today are more apt to prefer an environment with university colleagues with whom they can work than the attractions of a large, urban area. Practitioners who can serve part-time can be found in all three areas in abundance. However, neither Springfield nor Worcester are close enough to the parent university campus.

As for the Amherst area, there have been six professional groups who have surveyed the state for its medical school site, and all of them have ranked it first. Medical educators consider nothing more important to a new medical school than that it be located in the center of its parent university. It is the salient attraction in recruitment of a strong, full-time pre-clinical faculty, who can use its other departments. It is in the area of the Commonwealth, the west, that needs better medical care most, and it offers property that can be developed from scratch.

What position does Dean Berry take on this issue? He expresses himself strongly: "The new medical school should be located at Amherst, where it can be integrated with the parent university. No matter where it finally stands, however, I shall do whatever I can to help the new institution attain the highest standards of medical education and patient care."

Faculty Retirements

Three members of the faculty retired this summer to take the title of "emeritus." Ives Hendrick, who is regarded by his colleagues as "one of the great men" of his profession of psychiatry and psychoanalysis, has become clinical professor of psychiatry, emeritus, and has retired as chief of Harvard's teaching unit at the Massachusetts Mental Health Center. He continues as director of clinical psychiatry. Considered one of the pioneer developers of psychoanalysis in Boston and the rest of the country, he has made his mark: ". . . a large number of the present teachers of psychiatry in America are in the profession and in teaching because of the influence Dr. Hendrick exerted on them at Harvard."

Franklin F. Snyder, an authority on the respiration of the unborn, became associate professor of anatomy and obstetrics, emeritus, this June. Characterized by Dr. Berry as a distinguished investigator of ability, initiative and originality, he has long been concerned with the effect of narcotics used to alleviate the pain of childbirth.

Franc D. Ingraham left his post at the end of August to become associate professor of surgery, emeritus. At the same time he became neuro-surgeon-in-chief, emeritus, at the Children's Hospital Medical Center and retired as neurological surgeon at the Peter Bent Brigham.

New Emergency Clinic for Children's

"Approximately 400 children are rushed to our hospital each day for treatment. For many of them the frantic race would be in vain if it were not possible to give them immediate and comprehensive emergency treatment." These facts were stated by Dr. Leonard W. Cronkhite, Jr., '50, lecturer in preventive medicine and general director of the Children's Hospital Medical Center, when he announced the receipt of a gift of an undisclosed amount from Mr. and Mrs. George Sherman of Boston, Massachusetts, for the construction of a new emergency center to serve sick children who visit the hospital from all parts of New England. Plans for the emergency clinic are being made and construction is expected to begin in 1967. The new center, to be called The George Sherman Emergency Service, will constitute an area of major importance in reception and treatment of emergency cases.

Society of Brigham Surgical Alumni

The first annual meeting of the Society of Brigham Surgical Alumni took place in Chicago on October 5, 1964, at the time of the annual meeting of the American College of Surgeons. The secretary of the Society is Frederick P. Ross, '39, of Fitchburg, Mass.

With an Alumni body approaching 650 souls spread throughout the world, and with enthusiasm for the Society running high, it promises to be an eminently successful organization.

Its reasons for existing are: to raise funds in support of Brigham Surgical trainees; to supply placement advice to young surgeons finishing the Brigham training program and seeking surgical positions; to foster friendship among the Brigham's surgical graduates, old and young, and to offer them an opportunity to meet each other socially.

PROGRAM NOTES

One and a Half Million Gift

The James Foundation of New York has made an unrestricted gift of $1,500,000 to the Harvard Medical School. The Foundation recently distributed its $96 million principal to ninety-two charitable, religious, and educational institutions throughout the country. Harvard University received $4 million, which was one of the three largest gifts distributed. The Foundation, which stipulated what portions should be allocated to the College, the Medical School, the Divinity School and the Law School, was established in 1941 through the will of the late Arthur Curtiss James, railroad industrialist. Mr. James was one of the twelve wealthiest men in the country and also one of the least known to the public. The Foundation will be dissolved at the end of this year, in compliance with the terms of its original charter.

Alumni Over Halfway

Last June the Alumni phase of the Program for Harvard Medicine crossed the halfway mark toward its goal of $3.5 million when it received a total of $1.9 million. The Alumni have expressed their interest and enthusiasm in meeting this goal in various ways: one young Alumnus of both the College and the Medical School has signified his intention to contribute his income tax savings for the next two years to the Program; another Alumnus has pledged his fees for lectures and special advisory consultations during the next three years; while ten friends and colleagues of a recently deceased Alumnus have contributed to a fund in his memory in fulfillment of a wish, expressed before he died, to participate in the Program.

Grant from Surdna Foundation

In 1962 The Surdna Foundation of New York gave the Medical School a grant of $250,000 which established the John E. Andrus Teaching and Research Fund. The Foundation has recently repeated that gesture with a second grant of equal amount. Both grants are of an unrestricted nature which makes them doubly valuable to the Medical School: for support of the teaching and research activities of the senior faculty, and for the younger scholars who are destined to become future leaders in medical education.

Of Rats, Research, and Men

How are discoveries made? Do they spring fully formed from a man's mind; are they the result of long, hard work; or are they known, forgotten, then just rediscovered? At the new multi-disciplinary Elliott P. Joslin Research Laboratory which is devoted to the study of all aspects of diabetes, Dr. George F. Cahill, Jr., its director and assistant professor of medicine, explained how the laboratory has already made an interesting "bonus" discovery, which, as he said, "all came about by chance."

Not long ago, Dr. Cahill was reading of experiments being performed at Duke University by Dr. Schmidt-Neilson on a species of Egyptian sand rat. The rats at Duke were somewhat inexplicably but inexorably dying. However, Dr. Schmidt-Neilson and his team noted that the rats developed cataracts and after several months passed urine containing large amounts of sugar. Until that time only a few strains of mice and one hybrid mouse were generally known to contract a mild form of diabetes. Had the laboratory stumbled upon an animal that was naturally prone to diabetes? If so, these rats would give the researchers an excellent opportunity to observe the initiation and progress of the disease.

When the first batch of live sand rats arrived at the Joslin Clinic in August, they all seemed to be in good health. Almost at once, however, remarkable things began to happen; the rats fed on an exclusively high carbohydrate diet contracted diabetes within a few days and died, while those fed on a solely vegetable diet remained alive. So what began by "chance," or rather a hunch, may be a crucial link in making one of the greatest discoveries, the precipitating *cause* of diabetes.

An even better assurance for this accomplishment, however, is the new Elliott P. Joslin Research Laboratory in the Department of Medicine of the Harvard Medical School. Opened last June 6th, on what would have been Dr. Joslin's 95th birthday, the laboratory was toured by diabetes specialists, physicians, friends from all over the world and Boston dignitaries.

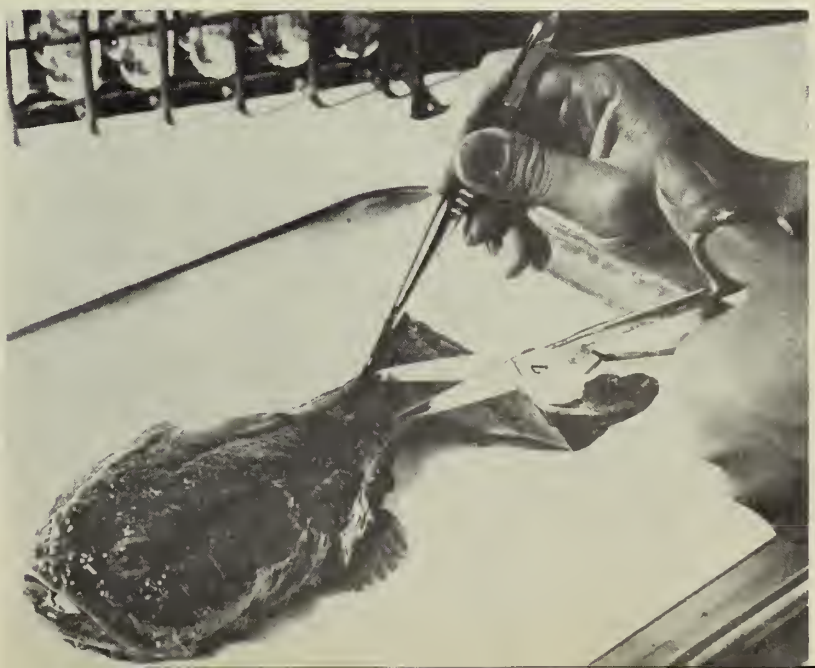
The occasion was, in a sense, the realization of a 46-year-old dream come true, for as far back as 1928 Dr. Joslin had borrowed money to buy the land upon which the laboratory and its parent building, The Diabetes Foundation, now stands. The research laboratory has been built onto the third and fourth floors, and thus completes another of Dr. Joslin's dreams, to have under one roof an inter-disciplinary practice-treatment-research building solely concerned with diabetes. The famed Joslin Clinic occupies the basement and first floor, and a hospital teaching unit, devoted to patients with diabetes, occupies the second floor. It is here that patients and sometimes members of their families come to live, in a motel-like atmosphere, while receiving treatment and special instruction. It had been Dr. Joslin's desire to wait until sufficient

funds were available before attempting to build what he hoped would be a truly significant research unit. By 1963 The Diabetes Foundation had raised $650,000 through private donations — two-thirds of the amount needed for construction — and through a grant of $328,-000 from Health Research Facilities Branch of the National Institutes of Health, the actual building of the laboratory began July, 1963. A further annual grant of $20,000 from the Adler Foundation is being used to support its work.

The Joslin Research Laboratory extends over half an acre and is probably the most complete research facility exclusively devoted to the study of diabetes in the world. Some idea of the range of this multi-research can be gathered from the following list of individual laboratory studies, all of which are being conducted simultaneously: glycoprotein, perfused heart, perfused liver, perfused kidney, immunoassay of insulin, insulin bioassay-adipose, insulin bioassay-in vivo, electron microscope research, clinical research, toadfish experiments-insulin in fish, and collation of information.

It is hoped that many new aspects of diabetes will become known, which in turn will become translated into new methods of treatment for diabetics. There is an atmosphere of expectation, almost excitement, about the work going on in the well-designed, light, airy and busy laboratory floors. Since Drs. Joslin, Banting, Best, et al., began generating that atmosphere long ago, the laboratory's work is a combination of the past's fundamental knowledge and that of today's highly specialized physicians, their imaginations and modern resources. A trip through the laboratory leaves one with the certainty that the laboratory needs only a few years more for millions of diabetics in this country to have more effective treatment than is known about today. Surely, by then diabetes may be no more threatening than to be born now with such errors of metabolism as phenylketonuria and congenital hypothyroidism?

Dr. George F. Cahill, Jr. (left), with a group of his colleagues, in one of the new laboratories.



A toadfish experiment in progress. These fish contain large amounts of insulin.

Photos by F. D. Devan & Dr. Sachar

A class practicing the proper way to register to vote.

Now is the Summer of our Discontent

By Edward J. Sachar, M.D.
Research Associate in Psychiatry

For eight, hectic, moving days last August, I worked with The Medical Committee for Human Rights* providing medical support to the civil rights workers in Mississippi. The Committee was developed out of deep concern for the health of some 800 young men and women in the Mississippi Summer Civil Rights Project. They had come there from all over the country and had committed themselves to helping Negroes register to vote. They found themselves working in areas where the established order was profoundly hostile to their presence, where access to local medical resources was uncertain, and where the environment posed serious hazards to their health.

The Medical Committee could only provide a "sympathetic medical presence," because it was enjoined by state law from actively practicing medicine. But the Council of Federated Organizations, which coordinates all the civil rights activities in Mississippi, enabled our committee members to act as health advisors to them and to the smaller units of workers scattered throughout the state. The Committee provided emergency first aid to civil rights workers who were beaten, shot or otherwise injured. We worked to develop liaison and good relations with local white and Negro physicians, and helped arrange referrals for workers who needed medical or hospital care. Committee members visited civil righters in jails and established the policy that they ask for a physician as well as a lawyer. Counseling was provided, by myself and other psychiatrists, to those who needed it. The Committee also carried out surveys of health conditions in the Negro communities and what medical facilities were available to them. In fact, we were involved, as one doctor put it, in a "total use of the self."

Arrangements were made by the Medical Committee for teams of about twelve physicians and nurses to be flown to Jackson every Saturday, where they were oriented by the previous week's medical team. Dr. H. Jack Geiger, assistant in medicine at the Harvard School of Public Health, was the project's field coordinator during the week I am about to describe.

When we arrived in Jackson we were driven to the committee's central office, housed in a rickety building and shared with the National Council of Churches, in the Negro community. There we met other colleagues and listened to their medical reports from Clarksdale, Greenwood, Hattiesburg, Meridian and other communities where the Committee had established its work. Dr. Robert Smith welcomed us on behalf of the local Negro physicians. A representative of the Lawyers Constitutional Defense Committee advised us on police harassment and the steps to take if we were arrested. A young Negro worker from the Student Non-Violent Coordinating Committee (SNCC), tried to explain the spirit of non-violence and also the chief current aim of the Summer Civil Rights Project — the voter registration drive. Finally, we were instructed about our personal security — always sign out where you are going and always remember to call back when you arrive there,

*The Medical Committee for Human Rights was formed in July, 1964, by a group of New York physicians, who were soon joined by colleagues from Chicago, Detroit, Los Angeles and other cities.

A COFO worker who was beaten up by white Mississippians receives first aid from members of the Committee.

travel in pairs, do not stand in lighted doorways and do not sleep near windows, and much more. During that meeting I confided to a colleague that I thought some of the instructions were a little melodramatic.

Within half an hour I changed my mind, for, as we were waiting to be driven to our lodgings, we received a call to help a worker at the nearby COFO office, who had been beaten with a baseball bat. Two of us were sent to help, and when we arrived at the scene I experienced the eerie sensation of becoming part of a newsreel. We found a young white boy, covered with blood, cradled in the arms of a Negro worker who was trying to stop the bleeding. The injured boy had been standing directly outside the office, working on a mobile Freedom Library truck, when a car filled with white men pulled up beside him. They jumped out and attacked him. After administering first aid we drove the boy to a local hospital. We were received coldly but correctly, and our patient received excellent and thorough care.

Our attention was shifted suddenly to Jim, a Negro worker who had accompanied us from COFO, for he now appeared to be getting emotionally out of control. It seemed that earlier in the evening one of Jim's friends had been shot by the segregationists in Greenwood. Jim

Dr. Sachar and the Project Leader from Marx with a neighborhood child.

Dr. Geiger at Tougaloo Clinic, drawing a blood sample from a worker.

Joseph K. Youngerman '68, watching a youngster practicing her ABCs.

himself had been shot in Greenwood the year before, and almost died. Now, because of this latest incident, his "non-violence" stand was beginning to falter. He tried to provoke the hospital personnel, he refused to leave the treatment room, he began to speak loudly and incoherently. Fortunately, we were able to calm him down and he went off in the care of Dr. Thomas Levin, a psychologist from New York, who was able to render a measure of psychiatric "first aid."

While we were still at the hospital, word arrived of another shooting and several cross-burnings around Jackson, so we stayed on in the waiting room. A hospital guard came in and said: "I don't agree with what you folks are trying to do, but I sure don't think violence like this can help anything, and I do hate to think of people I know doing it."

It was not long before another call came through for us, this time from our hotel, where calls had been received that if we returned to the hotel we would be killed. I finally spent my first night in Jackson sleeping on a floor, with another Committee member — the president of the Western New England Psychoanalytic Institute. Such was our introduction to Mississippi.

On the following day, Sunday, most of the physicians and nurses left Jackson for their field assignments. A few of us stayed behind to help set up a health clinic, under the direction of Dr. Geiger, for a group of 200 civil rights workers about to assemble for a conference at Tougaloo College.

By noon on Monday, we had mimeographed stacks of health forms, including symptom check lists, histories, physical exams, laboratory tests, referral sheets, environmental data questionnaires, and cards for health insurance — the latter to be underwritten by the medical committee. The faculty lounge at Tougaloo was transformed into a clinic with six examining cubicles and a clinical laboratory, all done with the aid of tarpaulins, sawhorses, partitions, cafeteria tables, bed sheets and safety pins. When the workers arrived, each filled out his forms and was guided through the makeshift clinic. First came the laboratory tests, then a dental examination, followed by a physical examination. Finally, each worker stopped at the desk of the supervising physician, indefatigable Bob Smith, of Jackson, who reviewed the diagnostic summaries and recommendations, wrote out necessary prescriptions and arranged for follow-ups and referrals when indicated. Two psychologists and I were located down the hall from the "clinic" for short-term counseling for all the workers

who were either referred or who themselves requested it.

We found ourselves involved in a curious combination of college counseling and military psychiatry. The group, with few exceptions, consisted of normal, young people who needed to talk to someone. Many of them wanted to describe particular experiences that had troubled them, and these interviews gave an indication of the kind of pressure under which they had been working. A New York boy, recently graduated from college, who had been working alone in a small rural town said:

> It wasn't until after the Sheriff threatened me that I really realized that I was in Mississippi, that I could be killed and nobody would protect me. That night in my room, I began to get more frightened than I had ever been in my life. I felt like I was drowning. I saw I could be shot through the windows, so I slept on the floor. During the day, it wasn't so bad when I was busy, but at night it really got to me. It lasted 6 or 7 nights, and then I got over it. I stayed with the Negro families, but I kept changing where I stayed, so as not to get them in trouble. I'd come in late and leave before dawn. You never knew for sure who you could trust. Once one of my own people told the police where I was for $2.

Another young man, who was a project leader, told us how a boy had been shot while sitting in the leader's car. Naturally he was concerned for the boy, but he was also disturbed by the thought — for whom were those bullets really meant? Perhaps they had been really meant for himself, and the other boy had been shot by mistake. He was struggling with the mixture of feelings this thought aroused.

There were other cases of "battle fatigue." A typical case was that of a 24-year-old Negro who had been active in the movement for three years, working every day without even a break at weekends. "I left the state one weekend, but then I heard there was trouble, and I felt worse than ever and I came right back." He told us he had worked in some of the most hostile parts of the state and had been jailed several times. A month earlier, his closest friend and confidant was jailed and now he had no one with whom to share his feelings. He looked exhausted and harried, and his symptom check-list revealed that he was having trouble sleeping, was becoming irritable and experiencing spells of depression. For several months he had noted postprandial stomach pains and now admitted that he was worried about having an ulcer. We advised him frankly that he was risking either a physical or an emotional breakdown, and that he needed immediate rest. Although reluctant at first, he discussed the situation with the SNCC leaders, and then arranged to spend a few weeks with a brother in New York.

Many of the other workers were also struggling with decisions, the most common of which was whether to stay on or go back to school. Either way, they felt guilty. One pretty, University of Michigan coed, who had decided to stay and work in the Freedom Schools, was worried about letting down her parents who had saved for her education. Another young college graduate from New York wanted to return to Law School, but he was concerned that he would be disappointing the Negro community with whom he had been working. "I know I could say I'd be more use to my people and the movement as a lawyer, but I think it really has to do with my selfish interest." Many of these interviews brought up one issue, the question of duty to oneself as well as to the movement, and the unhappy realization that the two obligations did not always coincide.

Others were trying to define their sense of "self" in relation to the movement. One Ivy League college student described how he had finally "found himself" as a Negro in the SNCC, particularly when it was a small, virtually all-Negro group, working in Mississippi to create a "blue-jeaned revolution" and helping the Negro communities to dispel their fear of whites. Now, however, the organization was ten times larger and as much white as Negro.

Batesville Freedom Library in the COFO headquarters.

Although he acknowledged this change to be in the best interest of the movement, it no longer held the same meaning for him, and he mentioned that a number of project leaders had recently applied to go to Alabama because there the movement was still in the pioneering stage.

Our own findings in Tougaloo and the combined experience of the physicians who had been in the field the previous weeks prompted Dr. Geiger to arrange a conference between the medical committee and the COFO leadership. Among other things, we strongly recommended to them the scheduling of regular rest periods for the workers, especially those who had been in rough sections. To implement this the medical committee offered COFO the use of a house in Jackson, solely for recreation and relaxation purposes, and indicated that the members of the medical committee would be willing to initiate much needed group discussions about common problems. COFO accepted the offer and the recommendations.

On Wednesday, those of us who had been in Tougaloo departed for our field assignments. Nora Maliepaard, a nurse from New York, and I drove to the COFO unit in Batesville. We interviewed the local white physicians, surveyed health conditions in the Negro areas and discussed the Negro's problems with an 82-year-old Negro minister, the Reverend Middleton, who barnstorms the county, driving his own jeep and preaching about the Bible and Civil Rights. We also witnessed some of the educational work of the civil righters — the rapidly growing Freedom Library, the classes of instruction for Negroes planning to try to register to vote, and a superbly performed play about Negro history, given in the local church by a band of traveling actors. This fall COFO plans to open a Community Center in Batesville, and we discussed plans with the Negro leadership for instituting health education classes as part of its program.

At the end of the week our entire group reassembled in Jackson, where each member delivered his report. While the staff were tabulating lists of friendly doctors, descriptions of hospital facilities, assessments of health conditions, I found myself recalling two events from my stay in Mississippi. The first was of a discussion with a pleasant, white, general practitioner in Batesville, who said, "I keep medicine and politics separate. I give the best medical treatment to everybody regardless, and in that respect I won't yield to pressure from either side."

The other scene that came to my mind was the memorial service in Philadelphia, Miss., that I attended. Services were being held in the charred ruins of a Negro church, set in a quiet grove of trees, for three civil rights workers who had been murdered in the town. Mrs. Chaney, the mother of one of the dead boys, spoke to the gathering. Struggling with her grief, she implored her people not to be afraid. The hymn singing was led by a frail Negro girl, who, at the end of the ceremony stepped forward to announce quietly, "We have opened our office in Philadelphia now. Come see us, and we will be coming around to talk to you." Her name is Jean and she is 22 years old. It was not until later that I learned what had happened to that little COFO Philadelphia office she was handling. It had been kept under armed "surveillance" for four days and nights by the town's whites. Only the presence of FBI agents prevented another tragedy from occurring. Fortunately, the MCHR's doctor-nurse team from Meridian made regular visits to Philadelphia, and it was they who drew up emergency plans against the possibility of major bloodshed.

The Rev. Middleton having his dressing changed by Nurse Maliepaard.

I am still worried about Jean, and all of her coworkers. It is some comfort to know that the Medical Committee for Human Rights has now become a permanent organization which will be working closely with COFO and National Council of Churches, to help meet the health needs of all the civil rights workers and the needs of the Negro communities of Mississippi.

Are Doctors Ignoring

It is only natural that men resent those who sue them, particularly the lawyers who carry the burden of such suits. In the patient-physician relationship, however, the resentment of a physician in a malpractice case is usually fierce and vociferous. The physician feels his reputation and integrity are challenged. He terms the patient an ingrate trying to avoid the payment of his bill. He blames fellow physicians for giving the patient the idea of making a claim. And he showers the attorney with epithets ranging from the devil's disciple to shyster, charlatan, ambulance chaser and a specialist in trading on a patient's misfortune and in suing and harassing an innocent victim of circumstances — the physician. Personal profit is always alleged to be the sole motive of the lawyer in pursuing this course. Perhaps physicians are in sympathy with the words of the Duke of York in Shakespeare's *King Henry VI*, "The first thing we do, let's kill all the lawyers."

This attitude is evident in the following quotes by physicians:

> I note there are increasing numbers of malpractice suits in the past five years. I don't believe that this increasing number is due to any increased amount of negligence on the part of the doctors or that the doctors are more ill-trained than they were prior to 1950. It seems obvious that the malpractice field has become quite lucrative for the attorney. I know that some lawyers will not take any plaintiffs' cases in this regard and on the other hand, others will fight their way to the door of the plaintiff. It has been my experience that 99 per cent of all malpractice cases arise from a vicious or even an inadvertent remark made by a doctor, a friend, or, let us call the next individual, a chaser.[1]

> A point worthy of discussion is the place of the attorney in malpractice suits. You should all know, if you do not already realize it, that the attorney who specializes in malpractice suits does not have a high opinion of organized medicine, which he sees as a coercive and self-protecting trust, uninterested in the rights of patients. It is here that closer cooperation between lawyers and doctors would be effective in changing these ideas.[2]

1. Willard Shabat, M.D., "The Doctor and Lawyer in Court," *Medical Trial Technique Quarterly,* 1956 ann. ed., 464.

2. Joseph F. Sadusk, Jr., M.D., "Some Observations on Causes of Physician Professional Liability," *Medical Annals of the District of Columbia,* March, 1964, XX, 3, 113.

It may surprise the medical profession that there is no such thing as a lawyer who specializes in malpractice cases. We should beware of the tyranny of labels. Even though several malpractice cases may be handled from one office, that fact does not make a lawyer into a malpractice specialist.

In any discussion of medical malpractice, we are ultimately forced to ask the question: "Should suits against physicians be permitted at all?" Some doctors argue that we should close our eyes to the isolated instances of an unfortunate result and think more of the dedicated service of the overwhelming majority of physicians who have done so much for the benefit of all mankind.

In this country we live under a government of law and not under a government of men. Government under law is the glory and boast of a free and sovereign people. With it we enjoy the blessings of freedom and liberty. Without it we are neither free nor sovereign. The law is the same for all. There are no exceptions in favor of a physician. This fact is expressly underscored by the Supreme Judicial Court in the case of Small v. Howard, 128 Mass. 131, where the court comments on the obligation of a general practitioner to his patient:

> . . . A civil engineer, a watchmaker, mechanic or blacksmith, for instance, is subject to the same rule of law.

Some physicians will also deny that there is ever any genuine case of medical malpractice. They say that at most there was an unfortunate accident, an inadvertent mistake, or an error in judgment, but not carelessness or negligence.

Nevertheless, there are cases in which a physician has treated his patient in a careless and negligent manner and it has been acknowledged by both responsible lawyers representing doctors in malpractice cases and by leaders of the medical profession:

> Doctors sometimes make mistakes, so do lawyers . . . but, unfortunately for the doctor, his mistake can result in a deformity, paraplegia or death and juries nowadays are more sympathetic to patients than they are in trying to preserve the good name of doctors.[3]

3. Charles J. and John F. Dunn, LL.B., "The Doctor and the Law," *Harvard Medical Alumni Bulletin,* May, 1959, p. 15.

the Law?

by Meyer H. Goldman, L.L.B.

> We cannot deny there are cases of actual malpractice or questionable conduct in which a patient suffers injury resulting from accidents, carelessness or ignorance on the part of a physician.
>
> The American Medical Association *has* never and *will* never avoid responsibility for the physicians in these cases. The persons injured as a result of such circumstances deserve compensation. That is why physicians carry professional liability insurance. It is one of the inevitable professional hazards in the admittedly difficult art of practicing medicine.[4]

Certainly insufficient educational preparation can lead to many suits. In a talk reported by the *New York Times,* May 28, 1959, page 33, Dr. Paul R. Hawley, director of the American College of Surgeons, was quoted as saying:

> . . . that today one-half of the surgical operations in the United States are performed by doctors who are untrained or inadequately trained, to undertake surgery.

GIVEN THAT EVERY INDIVIDUAL is entitled to his day in court to redress an alleged wrong, then care should be taken to correct the impression created by the word "malpractice." It would be more accurate to say that a patient is making a claim against a physician for professional negligence. The word "malpractice" suggests malevolent intent on the part of the physician, but its usage is akin to that of another expression that has been adapted loosely; that the defendant, that is, the person being sued in a motor vehicle accident case, is guilty of "negligence." In this state, the law governing the duty of a physician to his patient was defined in the case of *Small v. Howard,* when the Massachusetts Supreme Judicial Court described the duty of a general practitioner to his patient in the following terms:

> His contract, as implied by law, is, so far as this point is concerned, that he possesses that reasonable degree of learning, skill and experience which is ordinarily possessed by others of his profession. *It must be the ordinary skill, learning and experience of the profession generally . . .*

4. Louis M. Orr, M.D., former president of the American Medical Association, *American Bar Association Journal,* October, 1959, XLV, 1030-31.

> And, in judging of this degree of skill in any given case, regard is to be had to the advanced state of the profession at the time.
>
> One other point remains to be considered. It is a matter of common knowledge that a physician in a small country village does not usually make a specialty of surgery, and, however well informed he may be in the theory of all parts of his profession, he would, generally speaking, be but seldom called upon as a surgeon to perform difficult operations. He would have but few opportunities of observation and practice in that line such as public hospitals or large cities would afford. The defendant was applied to, being the practitioner in a small village, and we think it was correct to rule that 'he was bound to possess that skill only which physicians and surgeons of ordinary ability and skill, *practicing in similar localities, with opportunities for no larger experience, ordinarily possess;* and he was not bound to possess that high degree of art and skill possessed by eminent surgeons *practicing in large cities,* and making a specialty of the practice of surgery.'[5]

The Supreme Judicial Court also added that a physician:

> . . . is not responsible for errors in judgment, or mere mistakes in matters of reasonable doubt and uncertainty, provided he exercises ordinary skill and diligence. . .

Most of the explanation of why this law originated at that time can be found in its historical background. According to the secretary of the Massachusetts Medical Society:

5. Small v. Howard Case, *Massachusetts Reports,* November-June, 1879-80, CXXVIII, 131-6.

Mr. Meyer H. Goldman practices law in Boston. A graduate of Harvard College and Harvard Law School, he handles a wide range of cases. He is not, he emphasizes, a malpractice "specialist."

Prior to passage of the Medical Practice Act in 1894 anyone who chose might practice medicine in Massachusetts. He had but to announce himself a physician and he became one. He might assume a title to which he had no claim, and place a forged certificate upon his wall. The law could not interfere with his actions.

Previous to this time dating as far back as Colonial days, the Massachusetts Medical Society or its predecessors had been entrusted with the rights to examine practicing physicians. Those who passed the qualifications of membership in the Massachusetts Medical Society enjoyed certain privileges that other physicians did not enjoy, by statute right.[6]

In 1649 a law was passed in Massachusetts ordering 'that no person or persons whatsoever employed at any time about the body of men, women or children for preservation of life or health; as chirurgeons, midwives, physicians or others, presume to exercise, or put forth any act contrary to the known approved rules of art . . . without the advice and consent of such as are skillful in same art (if such may be had).[7]

In 1699 and subsequently the General Court of Massachusetts passed various acts intended to prevent the spread of contagious diseases, and in 1781 the act incorporating the Massachusetts Medical Society was passed. This noted 'that a just discrimination should be made between such as are duly educated and properly qualified for the duties of their profession' and others. It provided that the President and fellows of the Massachusetts Medical Society should have full power and authority to examine all candidates for the practice of physic and surgery.

Another act was passed by the legislature in 1789 directing the Massachusetts Medical Society to describe and point out the proper course of medical education for such candidates.

Such legislation gave the opportunity to well-trained physicians to prove their capacity to practice by joining the Massachusetts Medical Society. At no time was it provided, however, that the right to practice medicine in the Commonwealth be restricted to persons who had passed such examinations and become members of the Society. Until 1894 anyone who chose might practice medicine.[8]

Although the Supreme Judicial Court has from time to time applied variations of their rule in the case of Small v. Howard, most of the time the judge simply tells the jury to heed the second part of the ruling, that he have and use the skill of those in his community. In the case of a specialist the first part applies: he owes his patient the duty to have and use the care and skill commonly possessed and used by similar specialists in like circumstances.

Small v. Howard is still, and after almost a century, the major ruling upheld on standards of practice in Massachusetts. It does not seem illogical, then, to ask why, in view of great changes and advances in medicine since 1880, should not Small v. Howard be considered out of date as a precedent? Should not a general practitioner be held to the standard of care of *all* general practitioners acting in like circumstances? It seems to make no difference to the courts in Massachusetts that the general practitioner today, even in a small hamlet, is exceptionally well educated and trained, is subject to the Board of Registration in Medicine, must pass rigid examinations before he can practice his calling, and sees many patients a day. He belongs to various medical societies, receives many medical journals, and has access to modern medical libraries, hospitals, and specialists who are within easy reach, even in the greatest emergency.

IT IS ONE THING for our courts to lay down broad principles of law governing the duty of physicians to their patients. It is another thing for the patient to prove that the physician failed in his duty — for such proof, as a rule, requires the testimony of another physician conversant with the standards of physicians in a given community. Here the patient is confronted with a "conspiracy of silence." A doctor will not testify against his brother.

More and more courts have shown an awareness of this problem and have complained of the "well known reluctance of the members of the medical profession to testify against a fellow practitioner."[9] In a California case, the court stated:

> . . . gradually the courts awoke to the so-called 'conspiracy of silence.' No matter how lacking in skill or how negligent the medical man might be, it was almost impossible to get other medical men to testify adversely to him in litigation based on his alleged negligence.[10]

Informed writers give five major reasons why doctors are reluctant to testify against other doctors: they are bound by a professional courtesy frequently intensified by friendship and daily association; they feel reluctant to hurt a professional man's reputation because of one act of negligence; they visualize themselves in the same situation; they fear retaliation from medical societies and hospitals with which they need to remain in good standing; and they may have been advised or be afraid that

6. From a letter written by Robert W. Buck, M.D., to the author, Oct. 13, 1954.

7. *General Laws and Liberties of the Massachusetts Colony,* (Cambridge, 1672), p. 28.

8. From a letter written by Robert W. Buck, M.D., to the author, Oct. 18, 1954.

9. Carbone v. Warburton, 11 N.J. 418 (Supreme Court) 94 A 2nd 680, 684; (1953). Carbone v. Warburton, 22 N.J. Super 5 91 A 2nd 518, 522, (1952). 11 *NACCA Law Journal* May, 1953, pp. 176-177. Prosser, Torts 2d. ed. 1955, 210.

10. Salgo v. Leland Stanford, Jr., Univ. Board of Trustees, 154 Cal. App. 2d 560, 317 P. 2d 170 (1957).

their premium rates will be raised or their insurance cancelled altogether if they assist a plaintiff in a case against a physician.

To neutralize the advantage that the physician has enjoyed through this "conspiracy of silence," the courts and the legislature have been forced to develop new methods. They have applied the doctrine of *res ipsa loquitur,* that is, the result speaks for itself. The legislature has also enacted statutes permitting the use of medical textbooks in malpractice cases. In one jurisdiction the Supreme Court allowed the plaintiff to use medical textbooks as a substitute for medical testimony without benefit of a statute. The Court and Legislature have also, by judicial fiat and statute, permitted out-of-state doctors to testify, thereby removing the protective shield of the "same community" rule.

Most important, however, is the different view that some courts now hold on the Small v. Howard case. From the original ruling, it followed that a thing that was customarily done was customarily right, and the plaintiff was therefore unable to prove that the physician was guilty of any wrongdoing. This standard had become a protection for the physician rather than an impartial and objective rule of law designed to do justice to both sides. Today, however, some courts have reversed this ruling by stating that what is customarily done is not necessarily customarily right — it may be customarily negligent. Judge Learned Hand used this argument in a case on the question of whether certain safety measures on a boat were in accordance with the general standards that prevailed. He stated:

> There are, no doubt, cases where courts seem to make the general practice of the calling the standard of proper diligence; we have indeed given some currency to the notion ourselves . . . Indeed in most cases reasonable prudence is in fact common prudence; but strictly it is never its measure; a whole calling may have unduly lagged in the adoption of new and available devices. It never may set its own tests, however persuasive be its usages. Courts must in the end say what is required: there are precautions so imperative that even their universal disregard will not excuse their omission.[11]

Two years ago Justice Spiegel of the Massachusetts Supreme Judicial quoted Judge Hand's views with approval in his dissenting opinion in a malpractice case.

THERE IS NO SINGLE ANSWER to the problems of malpractice suits, but we suggest that the medical profession itself should try to do something to remedy the situation. One of the leading causes of malpractice suits is the absence of rapport between doctor and patient. That the patient feels strongly on this score is reflected in a poll conducted by the American Medical Association a few years ago. Patients complained that doctors:

> 60% — do not give patients enough time
> 54% — hide mistakes for other doctors
> 51% — are hard to find in an emergency
> 43% — charge too much
> 39% — do not show enough personal interest
> 31% — are too quick to perform surgery.[12]

A group of psychologists who conducted a study of the origins of malpractice suits concluded that:

> The growing malpractice problem is primarily a human relations problem and requires human relations research . . . suits are drastic symptoms of a breakdown in the relationship between the doctor and his patient . . . the origins of malpractice suits depend more upon how the patient feels about the doctor and how the doctor *acts* toward the patient. . .

In order to prevent claims from originating they recommended:

> development of standards of conduct for physicians in hospitals, so physicians 'will not feel the painful reluctance they do now in calling attention to substandard practices of a colleague.'[13]

Doctors also might consider: that a lawyer has a duty to his client; that immunity to suit only encourages laxity on the part of physicians; that it is human to err, and if the error is due to negligence, the injured party should be compensated. It is in the interest of the medical profession and the patients that doctors should act boldly and acknowledge their errors, and not ignore a fellow physician's negligence. In the *Cleveland-Marshall Law Review,* May, 1959, Dr. Miley B. Wesson advised physicians to never admit that the author of a textbook was an authority on the subject when they were defending themselves in a malpractice case. In my view, this was an open invitation to doctors to lie their way out of liability; the medical profession should openly disavow such conduct. Finally, doctors should give more than lip service to the by-laws of the Massachusetts Medical Society, which provides that counsel and assistance will be given to a plaintiff in a malpractice case if the claim has merit.

We might well paraphrase the words of the late Justice Cardozo, when he commented on the power of the courts to clean house in the legal profession:

> In the long run the power now conceded will make for the health and honor of the profession and for the protection of the public. If the house is to be cleaned, it is for those who occupy and govern it, rather than for strangers, to do the noisome work.

11. *The T. J. Hooper Case,* 60 F. 2d Cir. 737, 1932.

12. Richard Carter, *The Doctor Business,* pp. 25-6.

13. "Breakdown in Doctor-Patient Relationship is Shown by Malpractice Suits, Say Psychologists in C.M.A. Study," *Bulletin of the American College of Surgeons,* XLIV, 3, May-June, 1959.

EDITORIAL

"We Agree with Much of What He Says..."

In this issue of the *Bulletin* there appears an article by Attorney Meyer H. Goldman dealing with the sociological implications of claims against physicians based upon negligence, or, in the plainer language decried by Mr. Goldman, "malpractice." Much of what he says is provocative, some parts are controversial, and perhaps others are biased. Nevertheless, we believe it to be a stimulating and worthwhile critique. Mr. Goldman represented the plaintiff in a suit of "negligence" against two of the members of the editorial board of the *Bulletin.* In the tribulations and confusion that followed, he was invited to outline some of the views of the opposition in an article for the *Bulletin.* We agree with much of what he says.

Certainly the attitude of the physician toward the patient is critically important at all times. When the patient-physician relationship is a sympathetic one, malpractice suits are less likely to arise.

Certainly, too, the medical profession should not prevent redress for any obvious negligence suffered by patients at the hands of some of its colleagues. Nevertheless, Mr. Goldman's article leaves certain questions about his own profession unanswered. For instance, after a suit for negligence has been conducted by the best read and informed lawyers with profoundly biased "expert medical testimony," is it truly possible for a jury of laymen to either appreciate or decide the niceties of a point in medical technique or science? One might easily draw the analogy that a jury of medical men are not justified in using their medical knowledge to judge, say, the errors in a calculation made by a physicist that resulted in an abortive and tragic missile test.

If the physician is to be answerable to the law, so, by virtue of our democratic system, the law should be answerable to him, as to all men, to ensure him a just and true verdict.

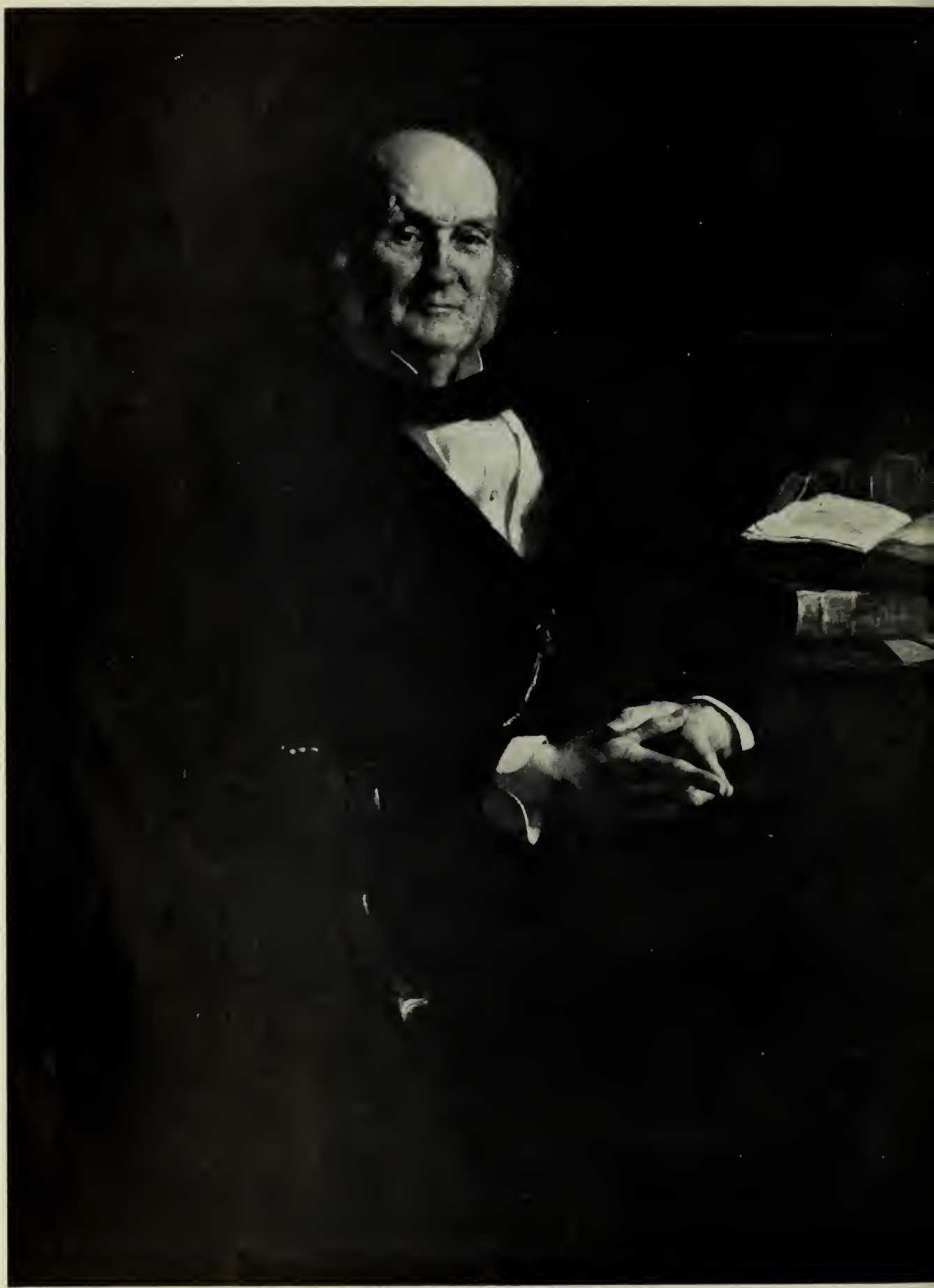
Mr. Goldman has failed to touch upon another problem, one which, surprisingly, could be called the antithesis of the famed "conspiracy of silence." When a patient has been treated by two physicians on a referral basis, it is possible, in fact it has been documented, for one to be so anxious to testify to his own adequacy that he automatically places the onus on the other.

We also add the following reasons for the reluctance of physicians to testify against each other to Mr. Goldman's list: the inevitable postponements, the interminable waiting to be called, the badgering by the lawyer for the other team, and the inadequate recompense for hours taken from one's busy practice.

In the *Harvard Medical Alumni Bulletin,* October, 1959, a letter to the editor and a companion editorial emphasized the need to modernize legal thinking on problems of malpractice in order to keep pace with the new steps in medicine. It was pointed out that the law need no longer read differently in the small country town and in the modern urban teaching and research center. It was also noted that in New Hampshire a doctor's jurisprudence committee had been in existence for some time, for the express purpose of making recommendations as to the presence or absence of true malpractice in any case under discussion. Today there is more nearly uniformity of medical and surgical practice throughout the country. It becomes clearer that the law itself has much yet to do to embrace and understand today's medical and surgical knowledge and its use throughout the country. Might not a state's own medical society become an informative liaison between the medical profession and the law? If in a manner similar to that occurring in New Hampshire, Massachusetts Medical Society's committee on professional liability were to prepare an informed but impartial opinion on the merits, or lack thereof, of a case, it could well act as the "expert witness" required to make a decision. That such a committee should assume any decision-making role, on the other hand, would clearly be wrong. A patient would hardly gain redress for negligence suffered if he were tried by a jury of the defendants' peers; and yet, within the framework of such a committee system it is possible to make both a more uniform, impartial, professional expression of medical opinion and ultimately a more meaningful decision.

Nevertheless, we repeat, the laws of the land must be served and the rights of the patients protected. It would seem to be the duty of any physician, when called upon, to give his best medical evidence or opinion. Law and medicine must labor together to deal with the unpleasant sociological implications about which Mr. Goldman is so concerned.

J. P. M.



David Humphreys Storer, portrait by Frederick P. Vinton, Boston Medical Library

THE ICHTHYOLOGIST DEAN

BY GEORGE E. GIFFORD, JR., M.A., M.D.

FROM the 1830's to the 1860's, when the masts and spars of trim merchant ships cast long shadows over the weatherbeaten wharves, Boston was intrigued and sometimes amused by its most prominent obstetrician, David Humphreys Storer (1804-1891). A striking figure, tall, slender, with a well-shaped head, sharply defined features and a full brow backed by a fanlike frame of wavy hair, Storer dressed in the "old school" manner: a full dress suit of black broadcloth with a large expanse of white shirt bosom, a long swallowtail coat and a tall silk hat. Often at daybreak, he could be seen scurrying along the fish wharves greeting the fishermen, peering into barrels and holds, and carefully noting the size and type of fishes within. In his urgent quest for specimens Storer even entreated the keepers of the sailor's boardinghouses to secure any shells or fishes that their guests might have obtained in foreign places.

Boston was tolerant of his preoccupation with fish, for Storer was visiting physician to the Massachusetts General Hospital, 1849-1858; professor of obstetrics and medical jurisprudence; obstetrician at the Boston Lying-In

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An instructor in psychiatry at HMS and junior associate in psychiatry at the Peter Bent Brigham Hospital, Dr. Gifford holds an M.A. degree in the history of science from Harvard University.

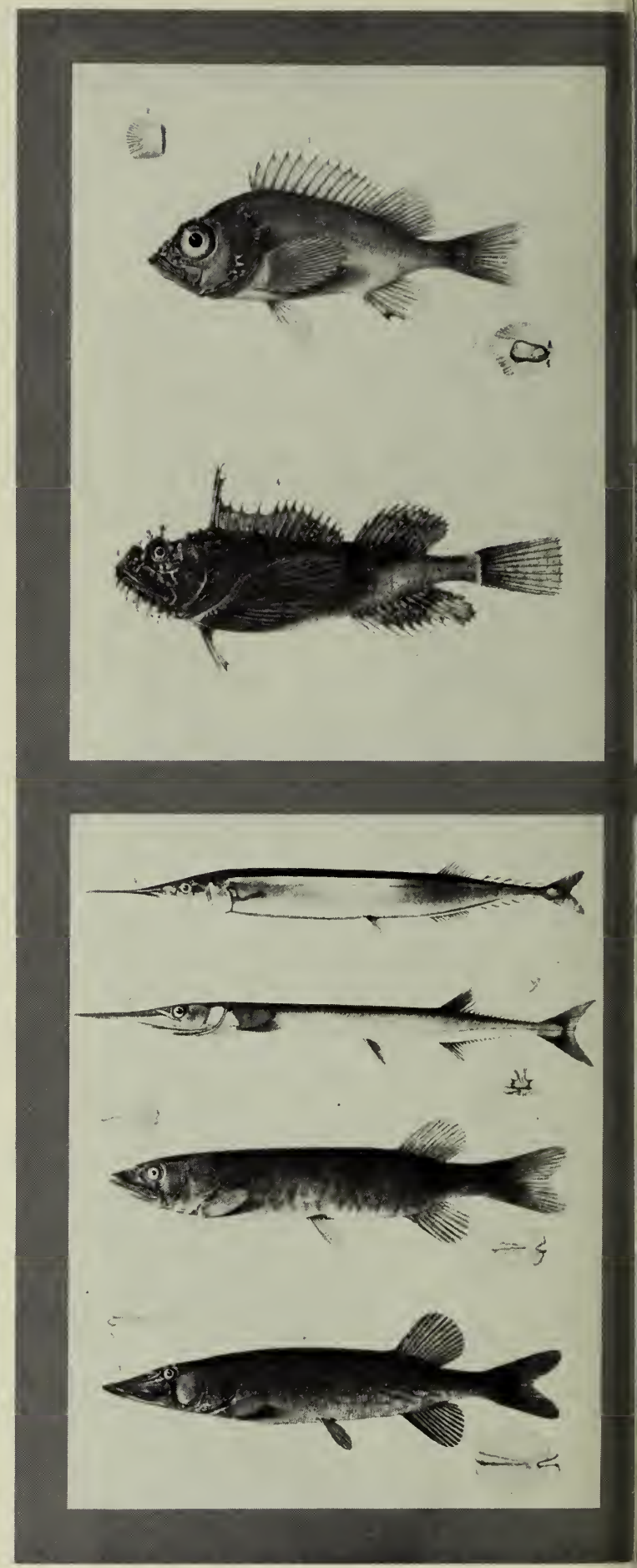

Figure 1: plate VII from Fishes of Massachusetts, *1867, showing the lithographic plates by A. Sorrel,* (Hemitripterus acadianus [*Storer*]). *Figure 2: plate XXIV from the same source,* Scomberesox storeri *(DeKay), hillfish.*

Hospital, 1854-1868; and dean of the Harvard Medical School, 1855-1864.

Storer was a Down-Easter, born in Portland, Maine. He was graduated from Bowdoin College in 1822 and then studied medicine under John Collins Warren. After he took his medical degree at Harvard in 1825, he began to practice in Boston, specializing in obstetrics. The Boston Lying-In Hospital was founded in 1832, mainly through the efforts of Walter Channing, and in 1838 Storer succeeded Channing as its attending physician. Dissatisfied with the four months' winter term then offered at Harvard Medical School, Storer, Oliver Wendell Holmes and Edward Reynolds, under the leadership of Jacob Bigelow, started the Tremont Medical School in 1837. As professor of obstetrics at Tremont, he pioneered in the use of the mannikin for teaching and in arranging for students to attend women in labor.

IT was not long before the enthusiasm and vigor of the Tremont faculty earned an enviable reputation, so much so that Harvard felt the necessity of reappropriating three of its teachers, first Bigelow, then Holmes, and later Storer. At the newly vamped Harvard Medical School, Storer succeeded Channing as professor of midwifery and medical jurisprudence and was considered its most effective teacher. One of his more ingenious teaching practices, many of which he had innovated at the Tremont School, was to pay practicing physicians in the Boston Dispensary two dollars for every maternity case turned over to the students. Storer's greatest contribution at Harvard, however, was the inspiration he gave to his students. Holmes said that "no one in his time did so much to make them love their Alma Mater."

As dedicated to medicine as he was, he was also consistently interested in ichthyology. In 1830 the Boston Society of Natural History was founded, and among its active members was a corps of naturalist-physicians who were largely the pioneers in both fields of biology and medicine. Of the seven officers chosen at its first meeting six were physicians, and of the eight curators chosen four were physicians. David H. Storer was successively recording secretary, curator of ichthyology and herpetology, and second vice president of the Society.

Storer's interest in natural history began with shells; in 1837 he translated the French naturalist L. C. Kiener's *General Species and Iconography of Recent Shells.*

Figure 3: plate VII from Volume II of The Boston Journal of Natural History, *1838-39, accompanying Storer's "A Report of Fishes of Massachusetts." It was drawn by Jeffries Wyman.*

It was in the same year that the Massachusetts Survey asked the Boston Society of Natural History to write reports on various groups of animals, and Dr. Storer volunteered to survey the reptiles and fishes of Massachusetts. His assignment was by no means easy; it required a scientific report within a year on a subject about which both he and the rest of the community were hopelessly ignorant, beyond what they knew of the "fish dealer and cook," and Storer admitted he "could scarcely tell a flounder from any other flatfish."

It was at this time that he began haunting the fish wharves. A biographer has added a sympathetic note:

> he (Storer) might be found busily engaged on specimens . . . from five o'clock in the early morning until breakfastime . . . Labor on fishes and reptiles was often of a very disagreeable character, the specimens received requiring transfer and preparation, few often in a condition far from pleasant to work on.

Despite these difficulties, Storer finished the *Report on the Fishes and Reptiles of Massachusetts* (1839). It was followed by *Synopsis of the Fishes of North America* (1846) and the classic, *A History of Fish of Massachusetts* (1867). (Figures 1 and 2.)

BY these works Storer helped continue the American natural history tradition of describing animals by specific states. The originator of this method was Mark Catesby, who wrote *Natural History of Carolina, Florida and the Bahama Islands* (1754), the first work to treat American fishes. Samuel Latham Mitchell, M.D., who was professor of natural history at Columbia College and founder of the first American medical journal, *The Medical Repository,* described the fishes of New York in 1815. Charles Alexandre Le Suer, the distinguished French artist and naturalist, was the first to study the fishes of the Great Lakes region and the basin of the Ohio River. In 1836 in the *Fauna Boreali - Americana,* Sir John Richardson gave a most valuable and accurate account of the fishes of the Great Lakes and Canada. Almost simultaneously Rev. Zadock Thompson completed a catalogue of the fishes of Vermont. Constantine Samuel Rafinesque, "a mad genius" professor of botany, natural history, and modern languages at Transylvania University, wrote the elaborate but unbelievable *Ichtyologia Ohiensis,* or the natural history of the fishes inhabiting the Ohio River and its tributary streams in 1812. Jared

P. Kirtland, M.D., one of the founders of Cleveland Medical College, the medical department of Western Reserve College, also described the fishes of Ohio. The amiable and scholarly James E. DeKay, M.D., who wrote a work on the fishes of Ohio, 1838, described fish in *The Zoology of New York.* John Edwards Holbrook, M.D., professor of anatomy at the Medical College of South Carolina, wrote the *Ichtyology of South Carolina* (1855-1857, 1860).

Storer described many original species; the first was a nut shell clam, which is not uncommon on both the New England and Pacific Coasts. Today it is called the Broad or Axe Yoldia, its scientific name being the *Yoldia thraciaeformis.* Storer found this new specimen in the entrails of a flounder, which also turned out to be a new species. He described several species of small minnows found in Alabama called Blue-breasted Darters, and one from the Ohio Valley called the Blue Darter. Most of the species that he discovered were salt water fish: the Northern Pipefish, Tunny, Johnny Darter, Ulva Fish or Radiated Shanny, a flounder called the Rusty-Dab (figure 3), the Yellow-tailed Flounder, and the Wrymouth.

Figure 4: **Epitonium Humphreysii** *(Kiener), or Humphrey's Wentletrap. Enlarged three times. Figure 5:* **Prunum cinctum** *(Kiener), or Marginella storeria. Enlarged three times.*

STORER's name lives on in several animals named for him by naturalist colleagues. Perhaps most interesting is the shell named for him — or more correct, middle-named for him by Kiener, the great French conchologist, whose works Storer translated. Kiener's dedication to Storer read:

> M. Humphreys, of the Academy of Science of Boston, has wished to help our research, in generously placing at our disposal a large shipment of shells collected in the country where he lives.

The shell, *Epitonium humphreysii,* is today called Humphrey's Wentletrap. This beautiful shell is about one half inch long, inhabits deep water, and occurs from Massachusetts to Texas. (Figure 4.)

In 1837, Joseph Pitty Couthouy, a young Boston seaman and member of the Boston Society of Natural History, read his first paper to the society. The new species of shell which he had discovered in "a box of shells from the Spanish Main" he named the *Marginella storeria.*

> I do myself a pleasure in naming this shell after my friend, D. Humphreys Storer, M.D., whose ardent love of Natural Science and devotion to its advancement among us are, too well

known, to require this feeble tribute as anything more than a token of my own personal sense of indebtedness to him; in laboring, to present the public with one faithful translation of Kiener's Iconography of Recent Shells.

The *Marginella storeria* is today known as *Prunem cinctum* (Kiener). (Figure 5.)

In 1839, another early physician-conchologist, John Clarkson Jay, M.D., wrote

> This is also one of the rarities brought home (from the Amazon River) by Captain Brown; and it is at his suggestion that I have named it after a very able and zealous naturalist, D. Humphreys Storer, M.D., of Boston.

Jay named it *Ampullaria storeria.* Today it is known scientifically as *Pomacea storeria* (Jay) and vernacularly as an apple snail.

Jared P. Kirtland, the physician-ichthyologist, named a large minnow, abundant in larger streams and lakes, from the Great Lakes and westward to Wyoming and southward to Arkansas, for his friend Storer; *Nocomis storerianus* (Kirtland) is known also as Storer's Chub.

In *A Report on Fishes and Reptiles of Massachusetts,* he described for the first time a small, secretive ground snake of spotty distribution in the mountainous part of the northeast. This red-bellied snake was renamed for Storer — *Storeria occipitomaculata* — by Baird and Girard, and the name *Storeria* applied to a new genus of small ground snakes. The red-bellied snake is sometimes still called Storer's snake. (Figure 6.)

David Humphreys Storer may be remembered as a distinguished obstetrician, but Humphrey's Wentletrap, Storer's Chub and Storer's Snake are living reminders that the Harvard dean was also a pioneer American conchologist and ichthyologist.

Dr. Gifford would like to thank Genevieve M. Scully, librarian of the Boston Museum of Science, and the late Richard W. Foster, associate in mollusks, Harvard University.

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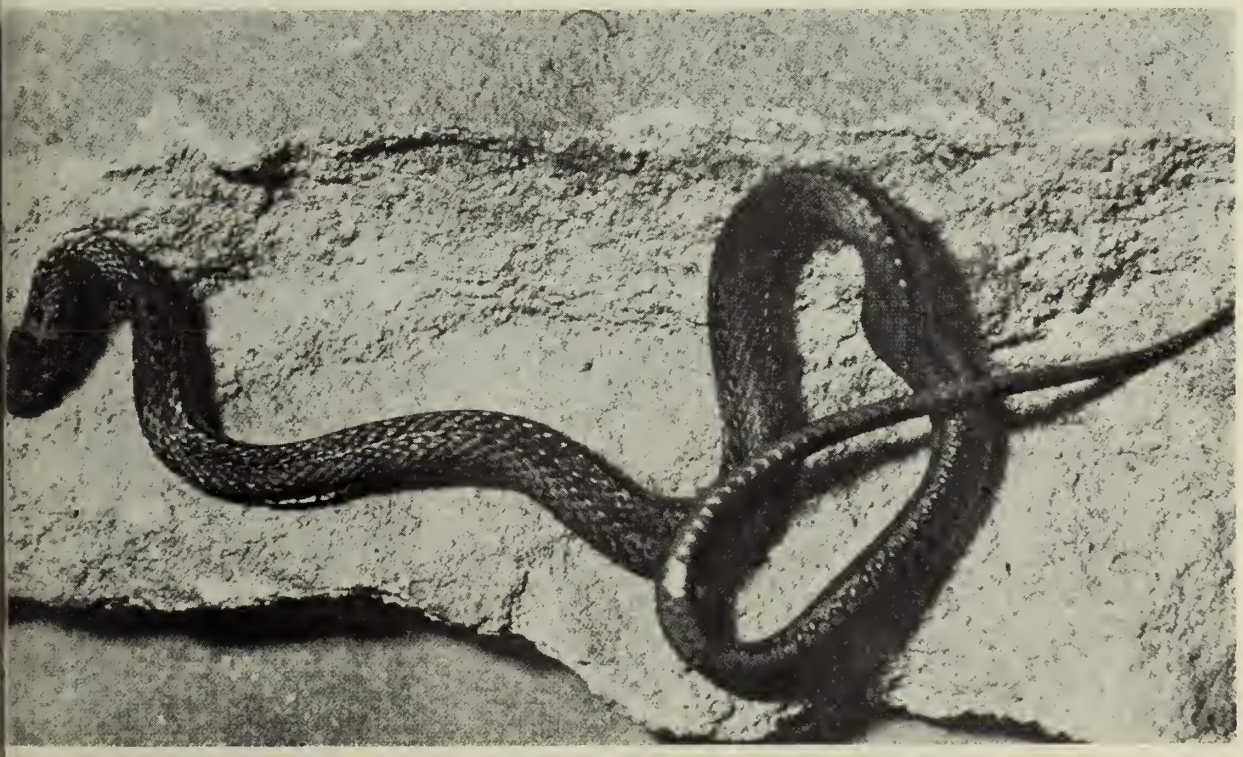

Figure 6: The red-bellied snake or Storer's snake. (Storeria occipitomaculata).

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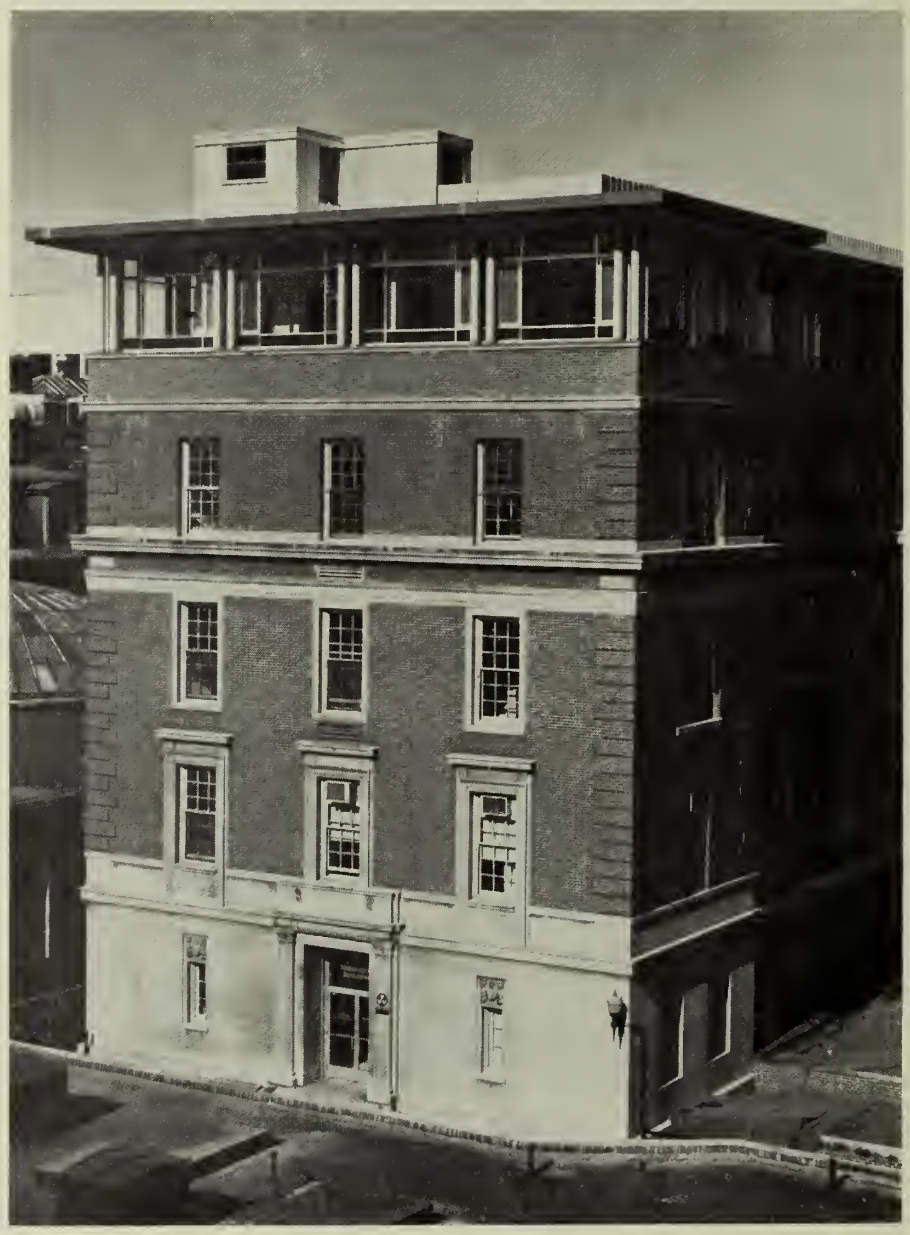

THORNDIKE MEMORIAL

by Maxwell Finland '26

In keeping with our times, presentations at the Harvard Medical Society in general have been primarily "basic" in their orientation and pitched to the molecular, or at most the cellular, level; so that terms such as biochemical or biogenetic pathways, energy transfers or potentials, RNA, DNA, genes, genomes, genetic code, chromosomes, ribosomes, and fine structure, have very properly recurred in their central themes. Some of the speakers from the basic science departments have occasionally apologized to their older clinical colleagues — but not, of course, to the students in their audience — for not relating their presentations directly to disease entities or to problems that could be considered of medical interest. Even one of our youngest clinical colleagues began his talk with an apology for not choosing a subject more clearly disease- or patient-oriented.

When I was invited to take up some of the precious time of one of these programs, I promptly declined because the nature of my own "academic" activities during the last few months has precluded any scientific explorations in depth. However, the program committee has been insistent, and the fact that I am here indicates that my arm has been twisted sufficiently hard and painfully. I shall not know for a time whether I have been permanently injured; I can only hope that those directly associated with me will not suffer any backlash injuries as a result.

Several factors prompted me to reconsider and come before you tonight — all of them bound up in the subject I have chosen:

Having recently been elected to the George Richards Minot Professorship of Medicine and directorship of the Thorndike Memorial Laboratory and the Second and Fourth Medical Services, which together constitute the Harvard Medical Unit of the Boston City Hospital, it soon became apparent that I had come heir to a great and unusual treasure, and it behooved me to take some sort of inventory of this heritage.

This also happens to be an important anniversary year. It was on June 1, 1864, that the first patient was admitted to the wards of the Boston City Hospital, and the history of this hospital is intimately bound up with the Harvard Medical School, from which it recruited its first house staff. We have also nearly arrived at the half-century mark of the firm establishment of the Harvard affiliation of the Fourth Medical Service and the 40th anniversary of the Thorndike Memorial Laboratory.*

As chairman of the committee on medical and scientific programs for this Centennial, I had occasion to review the attainments of the alumni of the Hospital and could not help but be impressed by the extraordinarily large number of them, particularly those of the Harvard Medical Unit, who have become leaders in academic medicine.

The last time I appeared before a major medical society, I reviewed in a rather broad manner the impact of nearly a lifetime of labor on the therapy of infections, and the result was rather discouraging; so much so that one of the leading national news magazines labelled it a "Jeremiad." When, in the following year, I presented similar material in an expanded form as part of the Shattuck Lecture, it might well have been characterized as "Lamentations." Now I was brought up on the *Old Testament* — in its original — and it seemed to me that this had gone far enough, so I thought it might be well to turn back in my *Bible* to *Song of Solomon*

Dr. Finland is George Richards Minot Professor of Medicine and head of that department at the Boston City Hospital. He is also director of the Thorndike Memorial Laboratory and the Second and Fourth (Harvard) Medical Services at that hospital. This paper was presented at the meeting of the Harvard Medical Society on April 7, 1964.

*Actually the Fourth Medical Service was authorized in 1914 and designated for Harvard in 1915 with Dr. George G. Sears, clinical professor of medicine, in charge. Dr. Peabody became director of the projected Thorndike Memorial Laboratory in the spring of 1921, the laboratories were completed and the staff began occupying them late in the summer of 1923, and the Thorndike Ward was opened to receive patients for study in November of that year. In 1930 the Second Medical Service was also designated for Harvard teaching and thus was created the present Harvard Medical Unit.

By way of comparison, it is of interest to note that the planning for the renovation of the Thorndike Building began in August 1956, the project was approved by the Administration and Board of Trustees of the Hospital in May 1957, a matching grant from N.I.H. was approved in January 1958, but the renovated building is *scheduled* to be opened sometime in June of this year — in time to be exhibited during the celebrations of the centennial year.

"In your patience possess ye your souls." ("Luke," XXI, 19)

("Song of Songs" in the literal translation from the original Hebrew), or even to *Psalms*. That now seemed more appropriate, for, in my new position I saw much to be praised and a good deal to sing about.

Having listened to the papers of this and of previous programs this year that dealt with "basic" studies of fundamental problems, it did not seem entirely inappropriate to present another aspect of our activities as an academic institution: namely the *results* of our teaching and training, namely *people*.

Finally, what I have to present may, by a very generous interpretation of the term, be encompassed in the term "scientific," in the sense of the descriptive, biological or of the more esoteric social sciences. For I shall be dealing with organisms — macroorganisms — indeed, human beings. And in a sense, I shall also be applying the scientific method, for I propose to enumerate the "materials," disclose their "sources," and present some measure of the "results." The methods were rather primitive, and no resort was had to any electronic apparatus or digital computors — not even punch cards or IBM machines; in fact simple pencil and paper were used, without even the aid of the abacus. Controls have not been included — neither contemporaneous nor matched.

The real authors of this paper, "the ones who did the work," so to speak, are my illustrious antecedents. The first of them is the late Francis Weld Peabody, perhaps best known at this School and elsewhere for his Gay Lecture on *The Care of the Patient*. The second is George Richards Minot, whose biographer, Frances M. Rackemann '12, named the "Inquisitive Physician," and whose penetrating inquiries into the minutiae of his patients' problems and close attention to details of the results of his ministrations to them earned him a Nobel Award. The third author is my immediate predecessor, William Bosworth Castle, now the first Francis Weld Peabody Faculty Professor, whose fundamental contributions were derived from the application of a great and penetrating intellect and the use of the simplest materials and methods. In the last *Bulletin* he presented the background of Harvard's participation in the Boston City Hospital and he has written the history of that unit in a somewhat more detailed *Centennial History of the Boston City Hospital.* *(This is reviewed on page 45.)*

My own participation in this paper is only as collector of data and scribe. I have chosen to present the material largely in tabular form, to indicate the academic sources of the material — i.e. of the people — who have constituted the Harvard Medical Unit at the Boston City Hospital, where they have gone and their academic achievement, by at least one measure of it, and their intellectual attainment as judged from one type of assessment by their peers. Like all biologic data, it is subject to change with time.

Although the scientific performance of the Harvard Medical Unit is not being reviewed here, this has been by no means inconsiderable, and continues to be both basic and clinically important.

Many people and institutions participate in, and may play roles of varying importance in molding the character of individuals and contribute in different measures to their success. It is well to emphasize that we are dealing here with only one subunit of a great Medical School and of an important Hospital, and that we are trying to assess the contribution of that sub-unit, realizing full well our indebtedness to the individuals and institutions that contributed to the development of the members of our staff before they came here, and, of course, the part played by those who furthered their development after they left.

Where Did They Come From?

Table 1 lists the medical schools or universities from which were graduated the 933 interns, residents, fellows and staff who have manned the Harvard Medical Unit at the Boston City Hospital since its inception. Similar data have been tabulated for the faculty of the Harvard Medical School. There are only 11 among the research fellows or research associates who have been at the Thorndike and held a Ph.D. or D.Sc., but not an M.D. degree; this, of course, is more frequent among members of the faculty of the Medical School, particularly in the preclinical departments. To simplify the comparisons, only the school awarding the M.D. is counted for those having more than one doctoral degree, and only those with a rank of assistant professor or higher in the faculty of the Harvard Medical School are included.

The data in Table 1 are summarized for convenience in Table 2. From the latter it is seen that the proportion of Harvard Medical School graduates coming to the Harvard Medical Unit at the City Hospital is only slightly, but not much, smaller than among those on the Faculty of the School. The considerably larger number of schools in the United States, and particularly those in foreign countries, contributing to the manpower pool of the Harvard Medical Unit at the Boston City Hospital, as compared with the corresponding numbers for the Faculty of the Medical School, is tempered by the fact

School Awarding M.D. (or Ph.D.)	Staff of HMU-BCH	Faculty of HMS*
United States		
Harvard	420	191
Columbia	35	13
Johns Hopkins	34	15
Utah	21	1
Cornell	18	6
California (San Francisco)	17	3
Yale	16	7
Pennsylvania	16	7
Tufts	15	6
Minnesota	14	2
Michigan	12	7
Boston U.	12	4
Downstate, New York	11	1
Stanford	11	0
Washington U.	11	1
U. of Chicago	10	7
New York U.	10	9
Cincinnati	9	2
Vanderbilt	9	1
Western Reserve	9	1
Wisconsin	9	0
Bowman-Gray	8	0
U. of Virginia	8	2
Emory	7	0
Duke	7	1
Rochester	7	3
Albany	6	1
Georgetown	6	0
Nebraska	6	3
Medical College of Virginia	6	0
Illinois	5	0
George Washington	4	2
Iowa	4	0
St. Louis U.	4	1
Southwestern	4	0
Colorado	3	3
Indiana	3	2
Maryland	3	1
North Carolina	3	0
Tulane	3	3
Upstate, New York	3	2
Alabama	2	0
Arkansas	2	0
Buffalo	2	1
Northwestern	2	7
Texas (Galveston)	2	0
U. of Washington	2	0
15 schools — 1 at HMU-BCH	15	2
5 schools — none at HMU-BCH	0	6
Total (except Harvard)	426	133
Foreign		
London	8	4
McGill	6	6
Brussels	5	1
Copenhagen	4	1
Karolinska Inst.	4	1
Beirut	3	0
Cambridge	3	2
Peking Union	3	0
Chile	2	0
Adelaide	2	1
Edinburgh	2	0
Oxford	2	0
St. John's (Shanghai)	2	0
Tokyo	2	0
Cape Town	2	1
Witwatersrand	1	2
Vienna	1	4
Paris	1	1
Leeds	1	1
Milan	1	1
Geneva	1	1
31 schools in 21 countries, 1 each at HMU-BCH	31	0
12 schools in 10 countries, none at HMU-BCH	0	14
Total (Foreign)	87	41

*Derived from the Directory, Faculty of Medicine, Harvard University, August 1, 1963. Those in the rank of "Associate" were excluded in order to conform to the categories included in subsequent tables.

Table 1. Academic Origins of Staff of Harvard Medical Unit at Boston City Hospital: Comparison with That of Faculty of Harvard Medical School

School Awarding M.D. (or Ph.D.)	*HMU-BCH* Number†	*HMU-BCH* Percent of Total	*HMS Faculty** Number†	*HMS Faculty** Percent of Total
Harvard	420(3)	45	191(6)	52
Other Schools in United States	426(4)	46	133(16)	36
Number of Schools	*61*		*39*	
Foreign Schools	87(4)	9	41(7)	11
Number of Schools	*52*		*26*	
All Schools, Total	933‡(11)	100	365(29)	100
Number of Schools	*114*§		*66*§	

*1963 Directory, excluding Associates
†Numbers of those with Ph.D. and no M.D. are shown in parenthesis.
‡Includes 35 current House Staff and 25 Fellows.
§Includes Harvard.

Table 2. Summary of Academic Origins

HMU-BCH*	Total in Group	Professors†	Associate Professors†	Assistant Professors†	All Professors†	Percent of Group	*Clinical Titles* Number	Percent of Professors
M	384	43^{4}	61^{1}	45^{1}	149^{6}	39	38	26
M,T	96	19^{4}	15	16	50^{4}	52	10	20
T	265	66^{11}	45^{3}	35	146^{14}	55	23	16
S	58	7	2	4	13	22	3	22
S,M	11	1	1	1	3	27	1	
S,M,T	21	4	6	1	11	52	2	18
S,T	38	25^{3}	3	6	34^{3}	89	4	12
Total	873‡	165^{22}	133^{4}	108^{1}	406^{27}	47	81	20
Deceased	81	13	4	9	26	32		
Living	792	152	129	99	380	48		

*M = House staff of 2d & 4th (Harvard) Medical Services; T = Thorndike Fellows and Residents; S = Staff of 2d & 4th (Harvard) Medical Services and/or Thorndike.
†Superscripts denote numbers of deans (including associate or assistant deans).
‡Excluding 60 current House Staff and Fellows.

Table 3. Professors, Associate Professors and Assistant Professors among Alumni and Staff of Harvard Medical Unit-Boston City Hospital

that the total number involved in the former is about 2½ times that of the latter.

With respect to the individual schools, as listed in Table 1, the contribution of the foreign ones cannot be compared because of the small numbers involved in each instance. However, the proportion coming from the different medical schools in the United States, considering only those that supplied the largest numbers (10 or more to HMU-BCH and 4 or more to the Faculty of HMS) was quite comparable, with a few notable exceptions. A considerably greater proportion came to the City Hospital unit from U. of Utah, Downstate New York, Washington U. (St. Louis), Stanford and U. of California (San Francisco), whereas a relatively greater number of the Faculty of the Harvard Medical School received their doctorate from University of Chicago, New York University, and Northwestern.

Academic Attainment

There are many measures of achievement that could be applied to physicians, teachers and scientists, some more difficult to quantify than others. For simplicity only two parameters were used, namely academic rank and election to selective medical societies; these are easy to enumerate, but like any other yardsticks that could have been used, they are rather crude. They do, however, provide a reasonable measure of the evaluation of the individuals by their peers and indirectly a very crude measure of the contribution of these individuals to medicine and to medical education.

The numbers of current and former members of the Harvard Medical Unit at the Boston City Hospital (excluding current Fellows and House-Staff) who hold or have held "professorial" rank — here used to include professor, associate professor and assistant professor — are listed in Table 3. These figures, and those in Tables 4 and 5 must be considered as minimums and concern only the ones for whom we had definite information as of April 1, 1964. The data in Table 3 are broken down according to academic rank and also according to the functions served on the Harvard Medical Unit.

It is seen that about 47 percent of all those who serve or have served in the Harvard Medical Unit have achieved professorial rank. Included among the professors are a goodly number, 27 we know about, who served as deans of medical schools, assistant or associate Deans, and some in higher administrative posts. About 20 per cent of the professorial titles were in the "clinical" category.

It is of interest to note here that not all of the professorships held by Alumni of the Harvard Medical Unit are confined to departments of medicine. As shown in Table 4, nearly all of the usual departments of medical schools are represented. The largest number of those in other departments are in preventive medicine, pediatrics, microbiology and psychiatry. Additional departments represented by 10 or 11 Alumni of the Unit with professorial rank are pathology, pharmacology, neurology and physiology. All told, 37 per cent of the professors hold such a rank in departments other than medicine. Table 5 also notes the fact that nearly one-third

Department	Number of Professors*
Preventive Medicine	29(18)
Pediatrics	18(3)
Microbiology	16(6)
Psychiatry	15(2)
Pathology	11(1)
Pharmacology	11(4)
Neurology	10(1)
Physiology	10(4)
Surgery	7
Biochemistry	6(2)
Radiology	6(3)
Obs. & Gynec.	4(1)
Dermatology	3
Tropical Health	2(1)
Ophthalmology	1
Nutrition	1
Totals — Number	150(46)
Percent†	*37(31)*

*The number of those also holding professorial rank in a department of medicine is shown in parentheses.
†Percent of total 406 professors (percent of the 150 who also hold professorial rank in Medicine).

Table 4. Departments Other than Internal Medicine in Which Alumni and Staff of HMU-BCH Hold or Have Held Professorships

of these same individuals also hold or have held a professorial title in the department of medicine in the same or at some other school.

Seeking another measure of the influence that the members of the Harvard Medical Unit at the Boston City Hospital may be exerting on medical education — at least at the level of the medical schools — I consulted the 1964 Directory of the Association of American Medical Colleges. Listed there are some 91 departments of medicine in the approved medical schools of continental United States, and among the individuals listed as chairman or head of these departments, 21, or nearly one-fourth of them, have been associated with the Harvard Medical Unit. There are at least 5 others who have held a similar position in the past and are not now listed. Among departments other than medicine in these schools, 19 are currently headed by former members of the Harvard Medical Unit of the Boston City Hospital and 10 others are known to have held such positions in the past.

Where Are These Professors?

Table 5 lists the schools at which former members of the Harvard Medical Unit at the Boston City Hospital hold or have held their professorships. Only those medical schools with 5 or more professors are listed by name. Harvard heads the list with 57; about half of that number are, or have been at the Boston City Hospital and the rest at the other Harvard-affiliated hospitals or in the preclinical departments. The other two medical schools in Boston lead the rest of the list — this is not surprising — and many of them have maintained some ties with the Harvard Medical Unit. Outside of Boston, the Medical Schools of the University of Illinois and Western Reserve harbor the largest number of professors from among former members of the Harvard Medical Unit at Boston City Hospital, with 14 each, followed by those of Seton Hall and Columbia, with 11 and 10, respectively. All told, the professors have been spread among 76 of the medical schools and 3 colleges in this country and among 30 medical schools in foreign lands. The "colonization" of certain of these schools by former members of the Harvard Medical Unit (and some also from

School or University	*Number of Professors**
Harvard	57
BCH 28	
MGH 9	
HSPH 6	
PBBH 4	
BIH 2	
CH 1	
Preclinical 7	
Tufts	18
Boston U.	17
Illinois	14
Western Reserve	14
Seton Hall	11
Columbia	10
U. of Washington	9
Minnesota	9
New York, Upstate	9
Cornell	8
Emory	8
Johns Hopkins	7
California, Los Angeles	7
California, San Francisco	7
Wisconsin	7
North Carolina	7
Cincinnati	6
Pennsylvania	6
Southern California	6
Yale	6
Buffalo	5
New York University	5
Pittsburgh	5
Rochester	5
Stanford	5
Tennessee	5
Utah	5
Med. College Virginia	5
8 Schools — each	4
9 Schools — each	3
17 Schools — each	2
16 Schools each	1

Summary

Schools	*Number of Professors*
Harvard	57
Medical Schools and Colleges in U.S.:	
6 Medical Schools — 10 or more each	84
22 Medical Schools — 5-9 each	142
47 Medical Schools — 1-4 each	104
3 Colleges	5
30 Foreign Medical Schools	39
Total: 109 Schools	431

*Includes Emeriti, Deceased, and overlaps (those who have held similar or higher ranks in other schools).

Table 5. Medical Schools and Universities at Which Alumni and Staff of HMU-BCH Hold or Have Held "Professorships"

other Harvard-affiliated Units) of the Boston City Hospital is an interesting subject in itself, but not for here.

Many of the professors, and a much larger proportion of those among the former members of the Harvard Medical Unit of the Boston City Hospital who are not directly connected with medical schools have made and continue to make notable contributions in other ways to the improvement of medical care, medical education and research and public health. They do this in their own community hospitals, where they hold key positions, and many of them hold important posts in research institutes, in the local, state or national health services, and in local and national professional societies. No attempt has been made here to quantitate these contributions, which are quite varied in type and scope.

It may not be inappropriate here to present another aspect of the participation of the Boston City Hospital, and particularly of its Harvard Medical Unit in the other departments at Harvard. This is illustrated in Table 6, to which I was first tempted to give the heading "Miscegenation at the Harvard Medical School," to indicate the intermarriage of the Harvard mainliners with their poorer cousins in the darker part of town. I thought better of that idea after considering the possible misinterpretations and implications, because of the peculiar location of our hospital and the turbulent climate of our time. The observations presented in that table, however, indicate the extent to which the Harvard teaching units at the Boston City Hospital have been integrated at the top level with those of other Harvard hospitals and departments. In this exchange of leadership during the past 4 decades or so, the City Hospital has acquired 6 of its department heads from other Harvard units, while contributing 9 heads to other departments of the Medical School — a big share from these poor relations.

*To BCH**	*From*	*From BCH**	*TO*
Peabody	PBBH	Blumgart	BIH
Churchill	MGH	*Churchill*	MGH
Castle	MGH	*Cobb*	MGH
Minot	PBBH**	Weiss	PBBH
Dunphy†	PBBH	*Adams*	MGH
McDermott	MGH	*Rutstein*	Prev. Med.
		Janeway	CH§
		Whittenberger	HSPH
		Ebert	MGH

*This table includes professors in departments other than medicine; their names are shown in italics. Drs. Janeway, Rutstein, and Whittenberger, however, held positions in HMU at BCH.
**Via MGH.
†"Divorced" (2 subsequent "remarriages").
§Via PBBH.

Table 6. Movement of Department Heads to and from Boston City Hospital Within Harvard

Membership and Leadership

In the special field of medicine and clinical investigation to which the Harvard Medical Unit at Boston City Hospital is devoted, the highest recognition is considered to be the election to the most select of these societies, the Association of American Physicians and its first offspring, the American Society for Clinical Investigation (Young Turks), the membership of which is finite. The extent to which the members or Alumni of the Harvard Medical Unit have been so recognized by these societies is summarized in Table 7 and 8. My attention was also more recently called to the fact that among the 61 members of the newly organized *Association of University Cardiologists,* 9 are present or past members of the Harvard Medical Unit of the Boston City Hospital.

Category	*Total Number*	*HMU - BCH Number*	*Percent*
Active Members	250	41	16.4
Living Emeritus Members	194	12	6.2
Active + Living Emeritus (totals)	444	53	11.9
Holders of Major Offices**	32	5	15.6
Years in Major Offices**	135	15	11.1

*Data from *Trans. Assn. Am. Phys.,* 1963.
**Beginning 1937.

Table 7. Participation of Alumni and Staff of HMU-BCH in Association of American Physicians*

Category	Total Number	HMU - BCH Number	HMU - BCH Percent
Active Members	309	22	7.1
Living Emeritus Members	524	88	16.8
Active + Living Emeritus (totals)	833	110	13.2
Officers**	94	22	23.6
Officer-Years	227	72	31.4

*Data from *1963 Directory of the Society.*
**Includes Councillors (3-year terms).

Table 8. Participation of Alumni and Staff of HMU-BCH in American Society for Clinical Investigation*

In summary, I have presented some data concerning the people who have constituted the Harvard Medical Unit of the Boston City Hospital, their academic origins and their positions in Academic Medicine. It is well to realize that this Unit constitutes only one-fourth of one of the major departments of the Harvard Medical School. When our dean represents this School as a breeding ground for leaders in medical education, one can begin to appreciate the significance of that assertion, for one has here a small measure of confirmation in at least one area of the School's assets and contributions. And, among ourselves, it is also well to bear in mind that these contributions came from the least-privileged and perhaps most neglected branch of the family, beset throughout most of its history by irritations and frustrations from many sources. That these achievements have been possible is a great credit to the School and to the community which together have supported and maintained it and, most of all, to its staff.

Those of us who have been privileged to stay for any length of time in this Unit and have been willing and able to endure it, feel fortunate in having been able to attract a large number, and to keep some of the good, basic output of the Harvard Medical School, namely its graduates along with a prudent admixture of the best that could be similarly attracted from many other schools. The physical accommodations and facilities that could be provided to these bright and eager young physicians have been modest indeed. In this lowly environment an earnest attempt has been made to uphold and maintain the high standard and quality of the race that the Harvard Medical School expects us to help breed and nurture. From all appearances this great experiment in cross-breeding of the Medical School and the City Hospital seems to have been a success.

In November, 1923, the late Mayor Curley stated:

> The dedication of the Thorndike Memorial Laboratory is without exaggeration the most important event in the latter day history of Boston; its activities will concern the whole country; its discoveries and achievements will interest all earth and add to the righteous pride and real glory of Boston.

As to Harvard's participation in the Boston City Hospital, I can only quote Dr. Castle: "The first hundred years are the hardest; let us hope they are not the best."

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ENTER CLASS OF '68

Sketches of the New Generation

Dr. Herman L. Blumgart '21, professor of medicine emeritus, conducts the 1964 Introductory Clinic on Registration Day.

Photos by J. Coyne & D. Bernstein

... Calvin J. Nafziger

To talk with Calvin Nafziger, even for a few minutes, would be quite enough to become aware that he is, to quote his own impression of Harvard, "very delightful." This compact, dark-haired, young man has an ease and courtesy, both in himself and in the way he presents his deceptively simple-sounding yet thoroughly probing thoughts on everything. His sense of humor is quickly aroused and his laughter is often loud and infectious. Here is what he said about himself and his impressions on his first day at the Medical School:

"I am the oldest child in what you would call a fair-sized Pennsylvania family — there are thirteen of us. My father is a laborer and Mennonite minister in Lancaster, but our community comprises only 25% of the population, and we are known as conservative Mennonites. All Mennonites do not dress the way I do; most of them please themselves whether they wear a collarless jacket like mine or an ordinary one. I went to Mennonite schools until the time came to go to college and then I chose to go to Lehigh College, Pennsylvania. I was interested in mathematics and natural sciences, so I decided against continuing my education in a Mennonite college because I felt I needed to broaden myself and my scope in those particular fields. I think I always

Barbara M. Hurwitz...

wanted to become a doctor, but I did not make up my mind until after I had taken a college course in biology, for then certain of my fears about the medical profession were allayed. At the same time mathematics seemed to be becoming more and more abstract, so I took a course in German sociology and history and tried to become generally more involved in other activities. In other words, my interest in math was flagging. During my last year I was awarded a Fulbright scholarship to the University of Tübingen in southwest Germany. I studied German philosophy, literature, and especially the people around me. I was also able to travel about Europe a little, and I had a wonderful time."

Calvin was a Phi Beta Kappa and graduated with high honors from Lehigh. "I had applied to several medical schools and had been accepted by a number of them; but Harvard was my first choice, because of what I had heard about its reputation, its excellent professors, and its fine research and clinical facilities. So, after waiting a long time to hear whether they wanted me, I was finally accepted.

"The first day here struck me as very delightful. How confident Harvard is, and how good the people are. You know, they are all very sure the school is the best. But everywhere everyone was very helpful. For instance, the student affairs office has already arranged for me to work in the library.

"I have no idea what specific area of medicine I will go into; I would rather wait and see what happens after I've learned something and had the chance to experience some clinical work." To what degree of excellence in his profession does he hope to attain? "Excellence? — That means a man who is excellent in everything. That epithet was the battle cry at Lehigh too, but for two years we all wondered what it really meant. I'm not sure I know yet, but perhaps I will in four years' time."

Barbara Hurwitz is a petite and beautiful young woman who gives the illusion of being much taller than she really is. She is a dynamic and bubbling person who has a unique way of imparting her thoughts in only a few words.

When asked what she thought was meant by "excellence," she answered: "Openness. To be aware of myself and the world, and adequately open to sources of information and people; to take it all in and then use it. Excellence cannot always be measured by marks." It is not surprising, therefore, that when she was interviewed before being accepted at HMS what mostly delighted her was that "this was the only medical school that didn't ask about my scientific-academic record. Instead we talked for two hours about books, the *New Yorker,* art, career mothers and so on. Harvard seems so aware of the whole person."

She claimed to be "overwhelmed and tremendously excited" on registration day and "struck by the astonishing acumen of people" around her. She spoke of how friendly everyone was, and it especially delighted her that Dr. White emphasized to the students their need for indoor and outdoor activities, because Barbara loves to dance, do water ballet, play the guitar and recorder, and sing. She had already heard of the HMS choral group and is eager to join it, and if she has time, she would like to join a modern dance school in Boston, "just for exercise and pleasure and to keep myself in trim." All of these activities, which one suspects Barbara does very well, must, in part, contribute to her vivacity. But her academic activities are also well defined and impressive. She majored in chemistry at Bryn Mawr, and has spent two summers working at the Sloan-Kettering Institute in a bacteriology laboratory. For the summer of 1963 she received a National Science Foundation grant in organic chemistry to study at Bryn Mawr, and last year she taught biology and chemistry to 12th graders in a summer school in South Daytona, Florida. She graduated magna cum laude and is the fourth girl to receive a Harvard Medical School National Scholarship.

When asked what she thought her future course might be, she said: "Oh, I don't really know, but I have wild plans of doing something in neurology. I would like to travel. Perhaps I will do something in the World Health Organization. I think international medicine is very important."

With her boundless enthusiasm for the things that interest her, one has the impression that the things this young lady considers important today will result in valuable contributions tomorrow.

William I. Bennett...

Bill Bennett's heavy shock of light brown hair, his somewhat pale face with its wide forehead, and his quiet manner, all combine to give him a slightly foreign look. He speaks fluently and sympathetically, using precise colorful language, and his conversation is both open and ruminative. The objectivity and originality of his perceptions make him a fine conversationalist.

In the broadest meaning of the word, Bill is somewhat of an iconoclast. Having entered Harvard with expectations for an academic career, he spent his first year deciding between a major in anthropology and Slavic studies. He finally discarded the first as too "methodological" and neither practical nor concrete enough and landed on the latter, which he considered more technical and hence more practical. In his second year, however, his two college biology courses took him by surprise: "for the first time in my life I became interested in science. I decided to switch from Slavic studies because I was tired of the dogmatism of its literature courses. I had thought science would be more dogmatic than literature, but I found that dogmatism has no place in science."

Toward the end of that year, however, he was offered a chance to go to Russia, by the Inter-University Committee on Travel Grants then mostly supported by the Carnegie Foundation, which he felt he could not turn down. In an experiment to see how long it took apt American students to converse in Russian, he spent two months of intensive study at the University of Indiana and a month touring Russia.

His first exposure to hospitals and medicine occurred through his volunteer work with the Phillips Brooks House mental hospital committee. During his last academic year, he and four other students took part in a cooperative venture with Phillips Brooks called the "Wellmet Project," in which they and seven chronically hospitalized schizophrenic patients lived under the same roof, maintaining the house with $20.00 contributions from each member. The patients were employed in the outside world but were simultaneously able to enjoy what Bill calls a "more stimulating, supportive atmosphere."

How did he feel about the project when the year was over? "There were a lot of misbegotten attempts to make things run well. It gradually fell upon me to be the "house manager," for we had no formulated plan of how things should run. There was a great feeling of urgency and duress, because there was so little time to do anything really significant. But I am not sure that I would change this; perhaps one of the benefical aspects of the experience for the patients was that they were able to help structure their world. It was a very important experience, from which I had a lot of pleasure and a lot of grief."

With a medley of interests, in literature, social science, psychology, and biology, Bill found it difficult to decide what to do after graduation. During 1962 and 1963 he worked part-time on two research projects concerned with juvenile delinquency in Roxbury and part-time at Widener Library as a reference assistant. It was through these projects that he met his wife, Myra. They were married this June. The following year found him enrolled as a special student at Harvard in the courses necessary for application to medical school. When he was accepted at the Medical School, he was awarded a Harvard College Graduate National Fellowship.

"When I was a junior in college, I flatly rejected the idea of becoming a doctor because of the inflated image doctors seemed to have. Later, with more maturity and when I knew several personally, I found that this image does not necessarily affect them. My old feeling about biology and my fiancée's belief that she could see me as a doctor also helped persuade me that this was the right choice." Before he applied, his mind was strongly fixed upon psychiatry — now he is not so sure. "The general practitioner may be gone, but the quality of the general man is still left in medicine."

Looking back, it seems as Bill's choice is the end of a six-year journey away from pure scholarship and toward a combination of it with the present, real world. He describes it in this way: "Although I have been running away from scholarship a long time, I have always admired the scholar's quality of perceptiveness and decency. Socialists use the word the 'decent' person to refer to those who make rugged demands on themselves to at least pay attention to people first. Add these two qualities to scholarship, and you have people who like to know about things in themselves, rather than those who put rigid professional interests first."

Walter B. Cannon...

From the time he was 14, Walter B. Cannon has had more than half an eye on the sky. Too young to learn how to fly at that age, he began gliding lessons at a school in Elmira, New York, in 1954, and he has been riding air lifts in sailplanes ever since. Although he is now licensed to fly, airplanes give him about the same pleasure that motorboats provide devoted sailors. Now a member of the Soaring Society of America, Walter has been teaching the skill for several summers to people ranging in experience from rank beginners to full-fledged airline jet captains. He has entered sailplane championships both locally and nationally.

Although he comes from one of Harvard's finest medical families — he is the grandson of the great physiologist Walter B. Cannon and the son of Bradford Cannon '33, who is a plastic surgeon and clinical associate in surgery at the Massachusetts General Hospital — Walter has made up his mind on medicine in his own time and way.

Since childhood he has been preoccupied with mechanical things. Starting with model trains, airplanes, then gliders, he took an engineering major at Harvard College and weighed this possibility heavily before leaning toward medicine. Although his father never pushed him toward medicine, in fact never even talks about medicine at home, the doctors and medical schools he encountered in his application interviews made him realize how much medicine was entwined with the values he had grown up with and taken for granted.

It seems reasonable that his interests other than aviation would include sports, particularly skiing, tennis and squash. He is considering combining engineering and aviation with his profession into something like aviation or aerospace medicine, but he says he is "going to try to go through medical school with an open mind."

A franker, more mature and pleasant person than Walter would be hard to find, and it is these same qualities that he enjoys most in human beings. "If more people had a sense of humor, I think there'd be a lot less trouble in the world. I feel humor and sincere friendliness are very important, and I hope to find this at Harvard Medical School.

It seems obvious that Walter will have an innate understanding of what is meant by "Caring for the Patient."

Olumuyiwa Oredugba...

Olumuyiwa, which means "God has brought me a son" in his Nigerian dialect of Yoruba, has wanted to be a doctor so long that he no longer remembers when he decided to become one. "At last," he says, "I will begin to study medicine, after all these years."

"Olu" Oredugba came to America in 1960 to study at DePauw University. The son of an administrative officer for the department of internal affairs in Lagos, Olu has been educated in the pattern of his father, who studied political science at the University of Minnesota. He is one of six children and his mother died when he was nine. Olu describes his father, who has remarried, as "very much a gentleman, very serious, and a very good sense of humor. He puts academic success above anything else, although he didn't choose my profession for me, and he has never tried to make any of my decisions for me."

A recipient of an African Graduate Fellowship, Olu comes to Harvard with high expectations. He feels that he is "going to like the way the faculty tries to correlate and integrate the various disciplines," and he hopes the students will help each other a great deal. He is happy that grades are de-emphasized here, for he felt that DePauw was too competitive.

When he arrived in this country, he was very disappointed that he could not begin his medical training immediately, as he would have done under the English system in his own country. To compensate for this, and because he is gifted in science, he took a heavy load of science courses at DePauw.

Olu is a handsome and urbane young man. Immaculately dressed in a conservative, dark plaid American sports jacket, slacks and well-polished shoes, he carries his light, 5′8″ frame erectly and athletically, and speaks casually in a soft, evenly clipped accent. He was a member of the DePauw track team and was considered Olym-

George A. Goldberg...

pic material, although he was unwilling to neglect his studies for that kind of rigorous training. He enjoys talking world politics; has been interested in national distinctions, both geographic and cultural, since his secondary school years; and is particularly fond of French literature, for its style and perceptivity.

Although America has left its mark on him, Olu has a definitely international perspective. "I don't know if I understand human beings, but actually, when you look at people, they are very, very similar. I have the feeling that people like to be together, somehow, though they sometimes seem as if they don't. Here in America they seem to be so independent-minded; this makes things so highly impersonal. I did notice, though, that in rural areas they are much less that way. In world politics I believe we should be our brother's keeper. There is a limit to this, I know, but I would rather go farther in that direction than in the opposite one. Things are more that way in Nigeria."

In spite of his national preference for dependence, Olu himself is very self-sufficient. "Nobody has told me what to do since my mother died." Certainly no one else is going to choose his wife. "Match me? No one will ever do that. In some traditional homes in Nigeria they try to, but, my goodness, they are not going to decide for me. After all, I am the one who will be living with her, not them."

Olu, therefore, has the difficult distinction of residing in two cultures. How does he feel about this? "I wouldn't deny that I've been much influenced by Western culture, but I wouldn't like to lose my own, for someday I am going back." He plans to practice and teach and is particularly concerned about the latter as the most immediate means of improving Nigerian medical care. An idealist who has taken all the practical steps to achieve his goals, Olu is certainly a son for whom his father can be thankful.

George Goldberg seems to be reserved and careful about the way he expresses himself, but this only hides an acute awareness of everything and everyone around him. He is dark and thin with a shy manner. His attitudes toward his role in society might well be illustrated by his reply to the question of what his own political affinities were. "I am a liberal," he says, "but I am always considered a conservative and not so 'far out' as most of my friends would like me to be. To give you an example: I believe we have got to have some change in Latin America, and though I prefer to have evolution, if we cannot get it, I will take revolution. I agreed with many things President Kennedy said and did, more than I expect to agree with any other president in my lifetime."

George Goldberg's father is a physician in Mount Vernon, New York, and his brother is also attending a medical school. He prefers to live in an urban area where he can enjoy and take part in a wide variety of non-academic interests, particularly in music. His own talents in this field are quite considerable; he calls himself a "decent amateur violinist. I have been going to music camp many summers and in 1962 I became concert master and president of the Harvard-Radcliffe Orchestra." Since his mother is a musician and has conducted choral groups for several years, perhaps he has inherited his love of music from her, while his ambition to be in medicine comes from his father. As he said: "If there's anything I am an evangelist about, it's music; maybe one day I will be one for medicine too."

A Harvard Medical School National Scholar, George graduated from Harvard College cum laude and as a junior Phi Beta Kappa.

Although George's father is a physician, he says he was not subjected to "direct family pressure" to become one himself. His decision has evolved slowly, through some of his experiences and from a broad range of academic achievements. While at Harvard college he had four different majors, history of science, biochemistry and social relations, but he finally narrowed them down to biology. He took as many courses as possible in the social sciences because it seemed to him "mathematics and pure science had the beauty of an icicle and . . . seemed non-substantial." He likes "to deal with people" and feels that within medicine is the perfect combination of art and science. His mind was not changed by his several months' travel in Asia on an unrestricted Sheldon Traveling Fellowship.

What in his opinion is the best kind of commitment? "There are many suitable ethics and ideologies, and excellent men come from everywhere." In George Goldberg's view "if you want an excellent man he must be educated and an active participant in the world. We have all been called 'brilliant' here today (at Registration). I don't feel brilliant at all, but I think one must have a certain confidence in oneself, and I am convinced the key is education, both ethical and academic." Many people would agree with his view.

Class of 1968

Adair, Richard F.
St. Paul, Minn. (Harvard)
Alpert, Joseph S.
New Haven, Conn. (Yale)
Anderson, Einar W.
Arcadia, Calif. (Stanford)
Baron, Deborah L.
Brookline, Mass. (Radcliffe)
Bennett, William I.
Tacoma, Wash. (Harvard)
Bialer, Rishon M.
Paterson, N. J. (Brandeis)
Bissell, John A.
Saratoga, Calif. (Stanford)
Boylston, Arthur W., 2d
Portland, Oregon (Yale)
Brandt, John H.
Lakewood, Ohio (Yale)
Breslow, Jan L.
Brooklyn, N. Y. (Columbia)
Brier, Arnold M.
Dayton, Ohio (Univ. of Chicago)
Brownstein, Carlton S.
Baldwin, N. Y. (Williams)
Burdick, James F.
Alfred, N. Y. (Yale)
Cannon, Walter B.
Lincoln, Mass. (Harvard)
[d]Cashion, Paul D.
Roslindale, Mass. (Coll. of the Holy Cross)
Chen, Lincoln C.
New York, N. Y. (Princeton)
Chivian, Eric S.
Millburn, N. J. (Harvard)
Cohen, Michael V.
New York, N. Y. (Harvard)
Colvin, Robert B.
St. Charles, Mo. (Massachusetts Inst. of Tech.)
[d]Cote, Donald E.
Rockland, Mass. (Coll. of the Holy Cross)
[d]Dinnerman, Peter M.
Portsmouth, N. H. (Univ. of New Hampshire)
[d]Director, Morris E.
Cambridge, Mass. (Harvard)
Dolgoff, Robert K.
Topeka, Kans. (Harvard)
Droller, Michael J.
Brooklyn, N. Y. (Harvard)
Eisen, Howard J.
Miami, Fla. (Harvard)
Ellsworth, George A.
Manhattan, Kans. (Kansas State Univ.)
Fielding, Jonathan E.
Mamaroneck, N. Y. (Williams)
Fisher, Judith K.
New York, N. Y. (Radcliffe)
[d]Flamm, Martin B.
New York, N. Y. (Columbia)
[d]Frank, Robert A.
Flushing, N. Y. (Queens Coll. of the City of N. Y.)
Frederick, Robert A.
West Orange, N. J. (Georgetown)
Friedlander, B. Colette
New York, N. Y. (Barnard)
Friedman, Paul A.
Baltimore, Md. (Princeton)
Funkenstein, Daniel L.
Boston, Mass. (Princeton)
Furlong, Maurice B., Jr.
Jamestown, N. Y. (Fordham)
[d]Goff, Paul H.
Plainview, N. Y. (Fairleigh Dickinson)
Goldberg, Alfred L.
Providence, R. I. (Harvard)
Goldberg, George A.
Mount Vernon, N. Y. (Harvard)
Goldberg, Michael E.
Eastchester, N. Y. (Harvard)
Goldenson, Ronald H.
Harrison, N. Y. (Princeton)
[d]Goldstein, Gary S.
Norwalk, Conn. (Univ. of Connecticut)
Gottdiener, Donna
Poughkeepsie, N. Y. (Wellesley)
Gradman, Wayne S.
Skokie, Ill. (Univ. of Chicago)
Grana, William A.
St. Louis, Mo. (Harvard)
Guss, Stephen B.
Omaha, Nebr. (Yale)
Hadler, Nortin M.
Eastchester, N. Y. (Yale)
Hanson, Charles W. D., Jr.
New York, N. Y. (Harvard)
Hawk, Alan B.
Pittsburgh, Pa. (Amherst)
Hejinian, John P.
New York, N. Y. (Harvard)
Herbert, M. Linton
Gainesville, Fla. (Wesleyan Univ.)
Herman, Judith L.
New York, N. Y. (Radcliffe)
Heuser, John E.
Tulsa, Okla. (Harvard)
Hochschuler, Stephen H.
Forest Hills, N. Y. (Columbia)
Holloran, James F., Jr.
Washington, D. C. (Coll. of the Holy Cross)
Hoyer, Stephanie F.
Los Angeles, Calif. (Reed)
Hurwitz, Barbara M.
New Rochelle, N. Y. (Bryn Mawr)
Jacobs, Paul S.
Lakewood, Calif. (Harvard)
Jakobiec, Frederick A.
Manchester, N. H. (Harvard)
Kahn, Henry A.
Poughkeepsie, N. Y. (Harvard)
Kelley, Jonathan M.
West Newton, Mass. (Princeton)
Kluft, Richard P.
Perth Amboy, N. J. (Princeton)
Kolonel, Laurence N.
Norwood, Mass. (Williams)
Krauss, Ronald M.
Buffalo, N. Y. (Harvard)
LaCombe, Michael A.
Ogdensburg, N. Y. (Univ. of Rochester)

[d]School of Dental Medicine

[d]LaMorgese, James R., Jr.
South Orange, N. J. (Franklin and Marshall)
Lang, John C., Jr.
Boca Raton, Fla. (Wesleyan Univ.)
Levine, Frederick H.
Queens Village, N. Y. (Columbia)
Levy, David E.
Verona, N. J. (Harvard)
Lobis, Robert A.
Philadelphia, Pa. (Univ. of Pennsylvania)
Looker, Andrew N.
New York, N. Y. (Harvard)
McBean, A. Marshall
Chatham, N. J. (Yale)
Marks, Richard A.
Urbana, Ill. (Harvard)
[d]Maron, Sheldon S.
Revere, Mass. (Boston Coll.)
Marshall, Robert A.
Dayton, Ohio (Oberlin)
Mattingly, Patrick H.
Bethesda, Md. (Coll. of the Holy Cross)
Mezan, Peter B.
Stamford, Conn. (Harvard)
Morain, William D.
Jefferson, Iowa (Grinnell)
Nafziger, J. Calvin
Lancaster, Pa. (Lehigh)
Oakes, David D.
LaPorte, Ind. (Harvard)
Omachi, Rodney S.
Stockton, Calif. (Stanford)
Onion, Daniel K.
Castleton, Vt. (Harvard)
Oredugba, Olumuyiwa
Lagos, Nigeria (DePauw)
Orkin, Fredrick K.
New York, N. Y. (Bowdoin)
Oyer, David S.
Rochester, N. Y. (Univ. of Rochester)
Patterson, Laird G.
Larned, Kans. (Univ. of Kansas)
Pauker, Stephen G.
Kingston, N. Y. (Harvard)
Pearle, David L.
Dallas, Texas (Amherst)
Peppercorn, Mark A.
Columbus, Ohio (Harvard)
Podell, Richard N.
Malverne, N. Y. (Amherst)
Pollard, Thomas D.
San Marino, Calif. (Pomona)
Posner, Michael K.
Longmeadow, Mass. (Yale)
Prager, Kenneth M.
Brooklyn, N. Y. (Columbia)
Reale, Vincent F.
Manville, N. J. (Princeton)
Reed, William P., Jr.
Reading, Mass. (Harvard)
Richards, Edith G.
St. Louis, Mo. (Wellesley)
Rieder, Ronald O.
Trenton, Mich. (Harvard)
Robertson, Howard T., 2d
Denver, Colo. (Colgate)
Rosenberg, Gary L.
University Heights, Ohio (Harvard)
[d]Roser, Steven M.
West Newton, Mass. (Middlebury)
Russell, Robin O.
Nampa, Idaho (Yale)
Rutherford, R. Carver
Seattle, Wash. (Univ. of Washington)
Sachs, David H.
Yonkers, N. Y. (Harvard)
Schneider, Bruce S.
West Englewood, N. J. (Harvard)
[d]Seldin, Edward B.
New York, N. Y. (Tufts)
Seward, Paul N.
New York, N. Y. (Stanford)
Simmons, Donald M.
Cincinnati, Ohio (Harvard)
Sloane, Robert W.
Wauwatosa, Wis. (Univ. of Michigan)
Soper, Michael R.
Independence, Mo. (Harvard)
Sos, Thomas A.
Forest Hills, N. Y. (Queens Coll. of the City of N. Y.)
Southmayd, William W.
Newton Centre, Mass. (Harvard)
Spitzer, Nicholas C.
Princeton, N. J. (Harvard)
Stanberry, Mark C.
Tucson, Ariz. (Univ. of Arizona)
Stulbarg, Michael S.
Cincinnati, Ohio (Massachusetts Inst. of Tech.)
Sun, Edward R.
Fayetteville, Pa. (Harvard)
Tolkoff, Nina E.
Brooklyn, N. Y. (Cornell Univ.)
[d]Trauring, Charles M.
New York, N. Y. (Columbia)
Trobe, Jonathan D.
Rio de Janeiro, Brazil (Harvard)
[d]Walling, Marlin W.
Sacramento, Calif. (Sacramento State Coll.)
Walsh, John V., Jr.
Buffalo, N. Y. (Boston Coll.)
Weil, Andrew T.
Philadelphia, Pa. (Harvard)
Weinstein, John N.
San Francisco, Calif. (Harvard)
Welch, John P.
Belmont, Mass. (Harvard)
Weyman, Lois J.
Cincinnati, Ohio (Cornell Univ.)
Whitfield, Richard W.
Rye, N. Y. (Brown)
Wittes, Robert E.
Woonsocket, R. I. (Harvard)
Yanovitch, John J.
Woodside, N. Y. (Manhattan Coll.)
Yanowitz, Ira S.
Bronx, N. Y. (Harvard)
Youngerman, Joseph K.
Champaign, Ill. (Yale)
Zawadsky, Peter M.
Spotswood, N. J. (Rutgers)
Zimet, Paul L.
New York, N. Y. (Columbia)

Harvard Medical Alumni Association
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When psychic tension mounts

Valium® (diazepam)

useful in alleviating

- –psychic tension mixed with depressive symptoms
- –psychic tension in the common psychoneuroses
- –psychic tension intensified by concomitant somatic disorders

How to prescribe Valium (diazepam)

Indications: Valium (diazepam) is of use in dealing with anxiety reactions stemming from stressful circumstances or whenever somatic complaints are concomitants of emotional factors. It is useful in psychoneurotic states manifested by anxiety, tension, fear and fatigue.

Valium (diazepam) may also be useful in acute agitation due to alcohol withdrawal.

Valium (diazepam) may be of use to alleviate muscle spasm associated with cerebral palsy and athetosis.

Dosage and administration	*Usual daily dose*
Mild to moderate psychoneurotic reactions: Manifested by anxiety-tension alone or with depressive symptomatology, agitation, restlessness, psychophysiological disturbances	2 mg to 5 mg, 2 or 3 times daily
Severe psychoneurotic reactions: Where severe anxiety, fear, agitation, aggression or hostility exist alone or with depressive symptoms	5 mg to 10 mg, 3 or 4 times daily
Alcoholism: As an aid in symptomatic relief of acute agitation, tremor, impending or acute delirium tremens and hallucinosis	10 mg, 3 or 4 times during the first 24 hours; reducing to 5 mg, 3 or 4 times daily as needed
Muscle spasm associated with cerebral palsy or athetosis	2 mg to 10 mg, 3 or 4 times daily

Contraindications: Valium (diazepam) is contraindicated in infants, patients with a history of convulsive disorders or patients with a history of glaucoma.

Warning: Valium (diazepam) is not of value in dealing with psychotic patients manifesting anxiety and should be avoided when there is reason to believe the patient is psychotic.

Precautions: In elderly or debilitated patients, it is important to limit the dosage to the smallest effective amount to preclude the development of ataxia or oversedation (not more than 1 mg, 1 or 2 times daily initially, to be increased gradually as needed and tolerated). As is true of all CNS-acting drugs, until the correct maintenance dosage is established, patients receiving Valium (diazepam) should be advised against possibly hazardous procedures requiring complete mental alertness or physical coordination. Driving an automobile during the period of Valium (diazepam) therapy is not recommended. In general, the concurrent administration of Valium (diazepam) and other psychotropic agents is not recommended. If such combination therapy is used, careful consideration should be given to the pharmacology of the agents to be employed with Valium (diazepam)—particularly with known compounds which may potentiate the action of Valium (diazepam), such as phenothiazines, barbiturates, MAO inhibitors and other antidepressants.

Since Valium (diazepam) has a central nervous system depressant effect, patients should be advised against the simultaneous ingestion of alcohol and other central nervous system depressant drugs during Valium (diazepam) therapy. Safe use of Valium (diazepam) during pregnancy has not been established. The usual precautions are indicated when Valium (diazepam) is used in the treatment of anxiety states where there is any evidence of impending depression; particularly the recognition that suicidal tendencies may be present and protective measures may be necessary. The usual precautions in treating patients with impaired renal or hepatic function should be observed.

Side effects: In clinical use, fatigue, drowsiness and ataxia have been reported; in most instances these are dose-related and may be avoided by proper dosage adjustment. Mild nausea and dizziness may occur on occasion. As with any new agent, when it is administered for protracted periods of time, periodic blood counts and liver function tests are advisable. Abrupt cessation after prolonged overdosage may, in some patients, produce withdrawal symptoms (e.g., convulsions, tremor, abdominal and muscle cramps, vomiting, sweating) similar to those seen with barbiturates, meprobamate and Librium® (chlordiazepoxide HCl). Changes in EEG patterns have been observed in patients during and after Valium (diazepam) treatment.

Paradoxical reactions, such as excitement, depression, stimulation, sleep disturbances, acute hyperexcited states and hallucinations have been reported. Other side effects noted have been blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash.

Valium (diazepam) is available as 5-mg and 2-mg tablets. For convenience and economy in prescribing, both strengths are supplied in bottles of 50.

Roche Laboratories endorses the principle of caution in the administration of any therapeutic agent to pregnant patients.

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